OMB No. 0935-0098: Approval Expires 04/30/98

FORM **MEPS-10**
(7-7-97)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

ESTABLISHMENT QUESTIONNAIRE

RETURN TO **Bureau of the Census**
1201 East 10th Street
Jeffersonville, IN 47132-0001

If you have any questions concerning this survey, please call

Please correct errors in name, address, and ZIP Code. ENTER number and street if not shown.

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

1. For this survey, a **health insurance plan** is defined as providing **hospital and/or physician coverage** for a **single premium** to employees and/or retirees. Exclude extra-cash plans (a specified number of dollars per day in the hospital) or dread-disease (e.g., cancer-only) plans.
2. Coverage could have been purchased from an insurance company, provided by a union or trade association, or self-insured by your company.
3. **Single and family** plans offered by the same insurance company and providing the same level of hospital and physician benefits count as **one plan**.
4. **High and low** options of a plan offered by the same insurance company count as **two plans**.
5. An **HMO** and a **conventional** plan offered by the same insurance company count as **two plans**.
6. If your company operates at more than one location, provide information for the **location on the label** unless otherwise directed.
7. Count **owners and officers** as employees in the enrollment questions if they were eligible for coverage along with the other employees at this location.
8. For the deductibles, copayments, and premiums, **report for typical situations and enrollees**. If cost varies by family size, use a **family of four**. If cost varies by age, provide the information for the average age of your workers.
9. **Estimates** are acceptable if you do not have this information readily available.
10. Provide information for the **pay period that included July 1, 1996** for characteristics such as coverage, premiums, and enrollment. Annual totals, such as costs, should be for **calendar year 1996**, if possible, or for the plan year that included July 1, 1996.

Section A – NUMBER OF PLANS

A1. Did you make available or contribute to the cost of any health insurance plans for your employees or retirees on July 1, 1996? *See instructions 1–5 above for a description of health insurance plans.*

001 1 ☐ Yes ↙ 2 ☐ No – **If No, go to Section D on page 5.**

How many? 003 ☐ ↙

Continue with Section B on page 2.

Section B – PLAN CHARACTERISTICS

B1. On July 1, 1996, what was the name of the health insurance plan with the highest enrollment and its carrier?

If you have received Supplemental Sheets (Form MEPS-10(S)) with plan names preprinted in Question B1, answer only for the preprinted plans. Otherwise, provide data for your 4 largest plans. You may make a copy of the Supplemental Sheet, or Section B of this form, if necessary.

FOR CENSUS USE ONLY

100

012 Name of plan

102 Name of insurance carrier

B2. Indicate the type of providers in this plan.

103
1 ☐ **Exclusive providers** – Enrollees must go to providers associated with the plan except in an emergency. There is typically no cost or a small fixed cost for each physician visit. (For example, HMOs, IPAs, EPOs)

2 ☐ **Any providers** – Enrollees can go to the physicians of their choice on a fee-for-service basis. The plan does not have any associated providers. (For example, conventional plans, indemnity plans)

3 ☐ **Mixture of preferred and any providers** – Enrollees can go to a set of "preferred" providers associated with the plan, or providers of their choice. If they go to a non-preferred provider, they face higher costs. (For example, PPOs, POSs)

B3. Did this plan **require** that the enrollee see a primary-care physician in order to be referred to a specialist?

104 1 ☐ Yes 2 ☐ No

B4. Indicate the type of indemnification of this plan.

105
1 ☐ **Purchased** from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses.

If purchased, go to Question B6.

2 ☐ **Self-insured** – Your company pays the claims from its resources and may charge a premium to employees. The plan may be administered by a *third party*. This type may employ supplemental *stop-loss insurance* to limit unanticipated losses.

For self-insured plans only:

B5a. Indicate if you administered the plan or if you employed a third party.

106
1 ☐ Self-administered
2 ☐ Insurance company or other administrator

b. Did you purchase stop-loss coverage?

107 1 ☐ Yes 2 ☐ No

B5c. Enter this establishment's **total annual cost** of coverage for this plan for the plan year that included July 1, 1996. Include: claims paid, administrative costs, and stop-loss coverage (if any). Include employer and employee contributions.

108 $ .00 *If this is the only plan you offered, also enter this amount in Question C3 on page 4.*

d. Enter the **monthly premium equivalents** (or the COBRA amount if premium equivalents were not calculated) for single and family (of four) coverage for a typical full-time employee. Include the costs entered in B5c. *Also enter this information in Question B11a (single) and B11b (family) – Total premium on page 3.*

109 $ .00 Single coverage

110 $ .00 Family coverage

e. Is the amount entered in B5d –

111
1 ☐ A premium equivalent?
2 ☐ A COBRA amount?

If self-insured, go to Question B7.

B6. Was this plan purchased through a pooling arrangement with other employers such as a multi-employer trust (MET) or a multi-employer welfare arrangement (MEWA)?

112 1 ☐ Yes 2 ☐ No

B7. Was this plan operated by a –

113 1 ☐ Union ↙ 2 ☐ Trade Association ↙ 3 ☐ Neither

114 Name of union or trade association | 115 Local number, if a union

116 Name of insurance representative

117 Address *(Number and street)*

118 City | 119 State | 120 ZIP Code

121 Telephone number

( )

B8. Did any enrollee receive a direct subsidy or contribution towards any part of the premium (e.g., from a union or government)?

122 1 ☐ Yes 2 ☐ No

B9. In what month did the plan year begin?

Enter a numeric response (e.g., Jan = 01, May = 05). 123 ☐☐ Month

Control No.

Section B – PLAN CHARACTERISTICS – Continued

B10a. For this plan, enter the total number of enrollees excluding dependents for this establishment on July 1, 1996.

124 ☐

b. Enter the total number of active employees enrolled.

125 ☐

c. Enter the number of former employees enrolled through COBRA or other State continuation-of-benefits laws.

126 ☐

d. Enter the number of retirees enrolled.

127 ☐ Total 128 ☐ 65 and older

e. Enter the **total** number of enrollees with **single** coverage.

129 ☐

B11a. Enter this plan's **total** premium, employer contribution, and employee contribution for a typical full-time employee with **single** coverage.

If self-insured, enter the monthly premium equivalent from Question B5d on page 2.

130 $ .00 Total premium

131 $ .00 Employer contribution

132 $ .00 Employee contribution

Indicate the premium period ↙

133 1 ☐ Week 2 ☐ 2 weeks 3 ☐ Month 4 ☐ Year

b. Enter this plan's **total** premium, employer contribution, and employee contribution for an enrolled **family** (of four).

Report for the same premium period as in Question B11a.

If self-insured, enter the monthly premium equivalent from Question B5d on page 2.

134 $ .00 Total premium

135 $ .00 Employer contribution

136 $ .00 Employee contribution

137 ☐ Family coverage was not offered

B12a. Did the **premiums** (not contributions) vary by –

Check all that apply.

138 ☐ Age?
139 ☐ Sex?
140 ☐ Number of persons (within family coverage)?
141 ☐ Wage or salary levels?
142 ☐ Other? – *Specify*
099 ☐

B12b. Did the **amount of the employee contribution** (not premium) vary for different employee categories (e.g., full-time, part-time, retiree)?

143 1 ☐ Yes 2 ☐ No

B13. Did this plan's **premium** include either of these services?

Check all that apply.

144 ☐ Life insurance 145 ☐ Disability insurance

B14. Enter the **annual deductibles** that enrollees paid out of their pockets before the plan began paying for covered services (using the plan's providers). Many HMO-type plans do not have deductibles.

146 $ .00 **Total individual annual deductible OR** ↙

Separate deductibles for:

147 $ .00 Physician care

148 $ .00 Hospital care

If the deductible is per overnight hospital stay, report under B15a.

149 $ .00 **Total family annual deductible** *(if applicable)* ↙

150 ☐ Number of persons – *Enter if the plan also specified that the family deductible was met when a number of family members fulfilled their individual deductibles.*

151 ☐ Plan did not have a deductible

B15a. How much did an **enrollee** pay for an **overnight hospital stay** (in a participating hospital, if applicable) after any annual deductible was met?

152 $ .00 → 154 1 ☐ Per day 2 ☐ Per stay

OR

153 ☐ Percent **OR**

155 ☐ Hospital care was not covered

b. How much did an **enrollee** pay for an **office visit** (with a participating physician, if applicable) after any annual deductible was met?

156 $ .00

OR

157 ☐ Percent **OR**

218 ☐ Physician care was not covered

B16. What was the maximum amount this plan would have paid for an individual –

a. Over the enrollee's lifetime?

159 $ .00

b. In one year?

160 $ .00

158 ☐ No maximum

Section B – PLAN CHARACTERISTICS – Continued

B17. What was the maximum annual out-of-pocket amount for –

a. An individual?

161 $ .00

b. A family (of four)?

162 $ .00

163 ☐ No maximum

B18. Indicate which of these services were included in the plan.

Check all that apply.

164 ☐ Routine mammograms
165 ☐ Adult routine physical exams
166 ☐ Routine pap smears

167 ☐ Office visits for prenatal care

168 ☐ Adult immunizations
169 ☐ Child immunizations

170 ☐ Well-baby care, under 1 year
171 ☐ Well-child care, 1–4 years
172 ☐ 100% well-baby care

173 ☐ Chiropractic care
174 ☐ Other non-physician providers
175 ☐ Outpatient prescriptions

176 ☐ Routine dental care
177 ☐ Orthodontic care

178 ☐ Nursing home care
179 ☐ Home health care

180 ☐ Inpatient mental illness
181 ☐ Outpatient mental illness
182 ☐ Alcohol/substance abuse treatment

B19. Could this plan have refused to cover persons with certain preexisting conditions?

183 1 ☐ Yes ↙ 2 ☐ No

Did this happen in 1996?

184 1 ☐ Yes 2 ☐ No

B20. Could this plan have imposed a waiting period for persons with certain preexisting conditions?

185 1 ☐ Yes 2 ☐ No

B21a. Is this plan offered in 1997?

186 1 ☐ Yes – **If Yes, go to Question B21c.**
2 ☐ No

b. If it is not still offered, indicate if it has been –

187 1 ☐ Replaced with a similar plan
2 ☐ Replaced by a substantially different plan
3 ☐ Dropped without offering a replacement – **Go to Section C.**

c. For 1997, enter the single and family enrollments and premiums for this plan or the one that took its place.

Report for the same premium period as in Question B11a on page 3.

188 ☐ Single enrollment

189 ☐ Family enrollment

190 $ .00 Single premium

191 $ .00 Family premium

Please complete one Supplemental Sheet for each additional hospital/physician plan you offered your employees and retirees on July 1, 1996. You may use photocopies of the Supplemental Sheet or Section B of this form, if necessary.

Section C – GENERAL HEALTH COVERAGE CHARACTERISTICS

C1a. Did you offer **optional** coverage (not included in the basic health coverage) for any of these services in 1996 at an additional premium to the employee?

Check all that apply.

192 ☐ Dental
193 ☐ Vision
194 ☐ Prescription drugs
195 ☐ Long-term care

b. What was the total amount paid for these coverages in 1996? *Include employer and employee contributions.*

196 $ .00

C2a. Did you impose a waiting period before new employees could be covered by health insurance?

197 1 ☐ Yes ↙ 2 ☐ No

b. What was the typical waiting period?

198 1 ☐ Less than 2 weeks
2 ☐ 2 weeks to less than 1 month
3 ☐ 1–3 months
4 ☐ More than 3 months

C3. Enter the total annual cost of coverage for the plan year that included July 1, 1996 for **ALL** hospital/physician plans that you offered **at this location**. *Include employer and employee contributions.*

199 $ .00

Control No.

Section D – EMPLOYMENT CHARACTERISTICS

D1. Enter the number of employees on your payroll at the location printed on the label for each of the categories below. Report for the pay period that included July 1, 1996. **If you offered health insurance**, also enter the number of employees eligible and enrolled for coverage through your organization. *Include officers and owners. Exclude leased, contract or agency workers.*

a. All employees

Total	Eligible	Enrolled
200	201	202

b. Part-time employees

Total	Eligible	Enrolled
203	204	205

c. Temporary (seasonal) employees

Total	Eligible	Enrolled
206	207	208

d. Were retirees eligible to receive health insurance (other than through COBRA or other continuation-of-benefits laws) on July 1, 1996?

219 1 ☐ Yes – *Check all that apply* 2 ☐ No

209 ☐ Retirees under 65 years
210 ☐ Retirees 65 years and over

D2. For the pay period that included July 1, 1996 –

a. Enter the number of women employees . . . . . 038 ☐

b. Enter the number of employees 50 years old or older . . . . . 039 ☐

c. Enter the number of employees who were union members . . . . . 040 ☐

d. Enter the number of employees who earned –

(1) Less than $6.50 per hour . . . . . 042 ☐

(2) Between $6.50 and $15.00 per hour . . . 043 ☐

(3) More than $15.00 per hour . . . . . 044 ☐

D3. How many hours per week must an employee work to be considered full time at your establishment?

041 ☐ Hours

Section E – COMPANY CHARACTERISTICS

E1. Do you offer any of these fringe benefits?

Check all that apply.

050 ☐ Paid vacation
051 ☐ Paid sick leave
052 ☐ Life insurance
053 ☐ Disability insurance
054 ☐ Retirement/pension plans
055 ☐ Medical Savings Accounts (MSAs)
056 ☐ Flexible spending accounts

057 ☐ Cafeteria plan –
Enter the average annual value per employee → 058 $ .00

E2. Which of these categories **best** describes your type of ownership?

Check only ONE.

062 1 ☐ S Corporation
2 ☐ Corporation
3 ☐ Partnership
4 ☐ Sole Proprietorship
5 ☐ Government (Federal, state, or local)
6 ☐ Joint venture or cooperative

E3. Is this a nonprofit business?

063 1 ☐ Yes 2 ☐ No

E4. Which of these categories **best** describes your principal business activity?

Check only ONE.

060 1 ☐ Retail trade
2 ☐ Personal services (e.g., beauty shops, dry cleaners)
3 ☐ Business services (e.g., advertising, computer processing)
4 ☐ Other services (e.g., legal and health services)
5 ☐ Manufacturing
6 ☐ Wholesale trade
7 ☐ Finance, insurance, or real estate
8 ☐ Transportation, communications, electric, gas, or sanitary services
9 ☐ Construction
10 ☐ Agriculture or forestry
11 ☐ Mining
12 ☐ Public administration

E5. How many years has your company been in business? *If you operate at multiple locations, enter the number of years in business for the entire enterprise.*

064 ☐ Years

E6. Enter the total number of employees your business has at all locations.

034 ☐ Employees

Section F – TO BE COMPLETED IF YOU DID NOT OFFER HEALTH INSURANCE COVERAGE

F1a. Has your business offered any health insurance as a benefit to the employees or retirees of this location since January 1, 1991?

031 1 ☐ Yes ↙ 2 ☐ No – **If No, go to Question F2.**

b. In what year did your business last offer health insurance coverage to the employees of this location?

032 | 1 | 9 | 9 | | Last year offered

F2. Did you pay the medical or hospital bills of your employees directly, other than for workers' compensation and/or injuries suffered on the job?

049 1 ☐ Yes 2 ☐ No

F3a. Instead of providing a health plan in 1996, did you provide a voucher or stipend to your employees which could be used to purchase health insurance?

045 1 ☐ Yes 2 ☐ No – **If No, go to Section G.**

b. Could this voucher or stipend be used for –

046 1 ☐ Health insurance/health care only?
2 ☐ Other purposes as well?

c. What was the average value per employee of this voucher or stipend?

047 $ .00 PER → 048 1 ☐ Week 2 ☐ 2 weeks 3 ☐ Month 4 ☐ Year

500 Remarks

Section G – PERSON COMPLETING THIS QUESTIONNAIRE

212 Name *(Please print)*	213 Title	
Signature		214 Date
215 Telephone number ( )	220 Extension	216 FAX number ( )	217 E-Mail address

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

OMB No. 0935-0098: Approval Expires 04/30/98

FORM **MEPS-10(P)**
(7-7-97)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

PERSON-LEVEL QUESTIONNAIRE FOR ESTABLISHMENTS

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Sections 903(c) and 308(d) of that Act specify that all information will be held in strict confidence by the staff of the Agency for Health Care Policy and Research and their authorized contractors.

RETURN TO **Bureau of the Census**
1201 East 10th Street
Jeffersonville, IN 47132-0001

If you have any questions concerning this survey, please call

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

1. In this questionnaire, "this person" refers to the individual named in the label area. A permission slip signed by the individual authorizing our collection of this information is included at the back of this reporting package.

2. "Your organization" refers to the location on the label of this questionnaire.

3. For this survey, **a health insurance plan** is defined as providing **hospital and/or physician coverage** for a **single premium** to employees and/or retirees. Also included in Section C of this questionnaire are single-service plans, which provide optional coverage not included in the basic health insurance plan(s) for an additional premium.

Section A – PERSON–LEVEL INFORMATION

A1. Which category below **best** describes this person's status with your organization on July 1, 1996?

065 *Check only ONE.*

1 ☐ A full- or part-time employee
2 ☐ A retiree
3 ☐ A former employee
4 ☐ A relative/survivor of a former employee
5 ☐ A seasonal or temporary employee

Go to Section B on page 2.

6 ☐ An employee of a temporary agency
7 ☐ An independent contract worker
8 ☐ No record of this person

Go to Section D on page 3.

Section B – HOSPITAL OR PHYSICIAN PLAN

B1a. Was this person **eligible** for hospital/physician insurance coverage through your organization on July 1, 1996?

350 1 ☐ Yes ↙ 2 ☐ No – **If No, go to Section C on page 3.**

If more than one plan was offered through this organization, answer Part b below. If only one plan was offered, go to Question B2a.

b. Of the hospital/physician plans offered by your organization, for which plans was this person eligible?

Please enter plan name(s) exactly as entered in Question B1 of the Establishment Questionnaire (MEPS-10) or Supplemental Sheet (MEPS-10(S)).

351 ☐ All **OR** ↙

501
502
503
504

B2a. Was this person **enrolled** in a hospital/physician plan provided by your organization on July 1, 1996?

231 1 ☐ Yes ↙ 2 ☐ No – **If No, go to Section C on page 3.**

If more than one plan was offered through this organization, answer Part b below. If only one plan was offered, go to Question B3.

b. In which hospital/physician plan(s) was this person enrolled?

Please enter plan name(s) exactly as entered in Question B1 of the Establishment Questionnaire (MEPS-10) or Supplemental Sheet (MEPS-10(S)).

352 ☐ All **OR** ↙

021
505

B3. What level of coverage did this person choose?

239
1 ☐ Single
2 ☐ Two adults
3 ☐ One adult/one child
4 ☐ Family (3 or more people)

B4. For the pay period including July 1, 1996, provide the information below regarding premiums paid for this person's hospital/physician coverage.

a. What was the **total premium including both employer and employee contributions?**

If this plan was self-insured, *enter the monthly premium equivalent. If a premium equivalent was not calculated, enter the COBRA amount.*

361 $ .00 PER →

376
1 ☐ Week
2 ☐ 2 weeks
3 ☐ Month
4 ☐ Year

B4b. How much did **this person contribute** towards his/her coverage?

Report for the same premium period as in Question B4a.

362 $ .00

OR

353 ☐ Percent of insurance premium

c. How much did **your organization contribute** towards this person's coverage?

Report for the same premium period as in Question B4a.

363 $ .00

OR

354 ☐ Percent of insurance premium

d. How much did sources other than your organization, such as a union or government, contribute towards/subsidize this person's coverage?

Report for the same premium period as in Question B4a.

355 $ .00

OR

356 ☐ Percent of insurance premium

OR

357 ☐ No subsidy/contribution from other sources – **Go to Question B6.**

B5. What was the source of the outside subsidy or contribution reported in B4d?

Check only ONE.

358
1 ☐ Union
2 ☐ Government
3 ☐ Other

B6. Was this person's insurance provided through COBRA?

359 1 ☐ Yes 2 ☐ No

Control No.

Section C – SINGLE-SERVICE PLANS

C1. On July 1, 1996, did this person obtain through your organization any optional coverage (not included in his/her basic health plan reported in Section B above) at an additional premium?

246 1 ☐ Yes 2 ☐ No – **If No, go to Section D.**

C2. Which of the following single-service plans did this person obtain?

Check all that apply.

370 ☐ Dental
372 ☐ Vision
371 ☐ Prescription drugs
373 ☐ Long-term care

C3a. What was the total premium for all single-service plans obtained by this person, including both employer and employee contributions?

374 $ .00 PER →

380 1 ☐ Week
2 ☐ 2 weeks
3 ☐ Month
4 ☐ Year

b. How much did **this person contribute** towards his/her single-service plan coverage?

Report for the same premium period as in Question C3a.

375 $ .00

OR

360 ☐ Percent of insurance premium

500 Remarks

Section D – PERSON COMPLETING THIS QUESTIONNAIRE

212 Name *(Please print)*	213 Title	
Signature		214 Date
215 Telephone number ( )	220 Extension	216 FAX number ( )	217 E-Mail address

OMB No. 0935-0098: Approval Expires 04/30/98

FORM **MEPS-10(S)**
(7-7-97)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

SUPPLEMENTAL SHEET ESTABLISHMENT QUESTIONNAIRE

INSTRUCTIONS

This Supplemental Sheet is a reprint of the questions in Section B of the Establishment Questionnaire (MEPS-10). You may use it to report additional health plan information. You may use photocopies of this Supplemental Sheet if sufficient copies were not included in your reporting package. Refer to the instructions on the first page of the Establishment Questionnaire (MEPS-10) when completing this Supplemental Sheet.

Section B – PLAN CHARACTERISTICS

B1. Enter the name of the health insurance plan and the insurance carrier.

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100

012 Name of plan

102 Name of insurance carrier

B2. Indicate the type of providers in this plan.

103
1 ☐ **Exclusive providers** – Enrollees must go to providers associated with the plan except in an emergency. There is typically no cost or a small fixed cost for each physician visit. (For example, HMOs, IPAs, EPOs)

2 ☐ **Any providers** – Enrollees can go to the physicians of their choice on a fee-for-service basis. The plan does not have any associated providers. (For example, conventional plans, indemnity plans)

3 ☐ **Mixture of preferred and any providers** – Enrollees can go to a set of "preferred" providers associated with the plan, or providers of their choice. If they go to a non-preferred provider, they face higher costs. (For example, PPOs, POSs)

B3. Did this plan **require** that the enrollee see a primary-care physician in order to be referred to a specialist?

104 1 ☐ Yes 2 ☐ No

B4. Indicate the type of indemnification of this plan.

105
1 ☐ **Purchased** from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses.

If purchased, go to Question B6.

2 ☐ **Self-insured** – Your company pays the claims from its resources and may charge a premium to employees. The plan may be administered by a *third party*. This type may employ supplemental *stop-loss insurance* to limit unanticipated losses.

For self-insured plans only:

B5a. Indicate if you administered the plan or if you employed a third party.

106
1 ☐ Self-administered
2 ☐ Insurance company or other administrator

b. Did you purchase stop-loss coverage?

107 1 ☐ Yes 2 ☐ No

c. Enter this establishment's **total annual cost** of coverage for this plan for the plan year that included July 1, 1996. Include: claims paid, administrative costs, and stop-loss coverage (if any). Include both employer and employee contributions.

108 $ .00

d. Enter the **monthly premium equivalents** (or the COBRA amount if premium equivalents were not calculated) for single and family (of four) coverage for a typical full-time employee. Include the costs entered in B5c. *Also enter this information in Question B11a (single) and B11b (family) – Total premium on page 2.*

109 $ .00 Single coverage

110 $ .00 Family coverage

e. Is the amount entered in B5d –

111
1 ☐ A premium equivalent?
2 ☐ A COBRA amount?

If self-insured, go to Question B7 on page 2.

B6. Was this plan purchased through a pooling arrangement with other employers such as a multi-employer trust (MET) or a multi-employer welfare arrangement (MEWA)?

112 1 ☐ Yes 2 ☐ No

Section B – PLAN CHARACTERISTICS – Continued

B7. Was this plan operated by a –

113 1 ☐ Union ↙ 2 ☐ Trade Association ↙ 3 ☐ Neither

114 Name of union or trade association	115 Local number, if a union

116 Name of insurance representative

117 Address *(Number and street)*

118 City	119 State	120 ZIP Code

121 Telephone number

( )

B8. Did any enrollee receive a direct subsidy or contribution towards any part of the premium (e.g., from a union or government)?

122 1 ☐ Yes 2 ☐ No

B9. In what month did the plan year begin?

Enter a numeric response (e.g., Jan = 01, May = 05). 123 ☐☐ Month

B10a. For this plan, enter the total number of enrollees excluding dependents for this establishment on July 1, 1996.

124 ☐☐☐☐☐

b. Enter the total number of active employees enrolled.

125 ☐☐☐☐☐

c. Enter the number of former employees enrolled through COBRA or other State continuation-of-benefits laws.

126 ☐☐☐☐☐

d. Enter the number of retirees enrolled.

127 ☐☐☐☐☐ Total 128 ☐☐☐☐☐ 65 and older

e. Enter the **total** number of enrollees with **single** coverage.

129 ☐☐☐☐☐

B11a. Enter this plan's **total** premium, employer contribution, and employee contribution for a typical full-time employee with **single** coverage.

If self-insured, enter the monthly premium equivalent from Question B5d on page 1.

130 $ .00 Total premium

131 $ .00 Employer contribution

132 $ .00 Employee contribution

Indicate the premium period ↙

133 1 ☐ Week 2 ☐ 2 weeks 3 ☐ Month 4 ☐ Year

b. Enter this plan's **total** premium, employer contribution, and employee contribution for an enrolled **family** (of four).

Report for the same premium period as in Question B11a.

If self-insured, enter the monthly premium equivalent from Question B5d on page 1.

134 $ .00 Total premium

135 $ .00 Employer contribution

136 $ .00 Employee contribution

137 ☐ Family coverage was not offered

B12a. Did the **premiums** (not contributions) vary by –

Check all that apply.

138 ☐ Age?
139 ☐ Sex?
140 ☐ Number of persons (within family coverage)?
141 ☐ Wage or salary levels?
142 ☐ Other? – *Specify*
099 ☐☐☐☐☐

b. Did the **amount of the employee contribution** (not premium) vary for different employee categories (e.g., full-time, part-time, retiree)?

143 1 ☐ Yes 2 ☐ No

B13. Did this plan's **premium** include either of these services?

Check all that apply.

144 ☐ Life insurance 145 ☐ Disability insurance

Control No.

Section B – PLAN CHARACTERISTICS – Continued

B14. Enter the **annual deductibles** that enrollees paid out of their pockets before the plan began paying for covered services (using the plan's providers). Many HMO-type plans do not have deductibles.

146 $ .00 **Total individual annual deductible OR**

Separate deductibles for:

147 $ .00 Physician care

148 $ .00 Hospital care

If the deductible is per overnight hospital stay, report under B15a.

149 $ .00 **Total family annual deductible** *(if applicable)*

150 Number of persons – *Enter if the plan also specified that the family deductible was met when a number of family members fulfilled their individual deductibles.*

151 ☐ Plan did not have a deductible

B15a. How much did an **enrollee** pay for an **overnight hospital stay** (in a participating hospital, if applicable) after any annual deductible was met?

152 $ .00 → 154 1 ☐ Per day 2 ☐ Per stay

OR

153 Percent

OR

155 ☐ Hospital care was not covered

b. How much did an **enrollee** pay for an **office visit** (with a participating physician, if applicable) after any annual deductible was met?

156 $ .00

OR

157 Percent

OR

218 ☐ Physician care was not covered

B16. What was the maximum amount this plan would have paid for an individual –

a. Over the enrollee's lifetime?

159 $ .00

b. In one year?

160 $ .00

158 ☐ No maximum

B17. What was the maximum annual out-of-pocket amount for –

a. An individual?

161 $ .00

b. A family (of four)?

162 $ .00

163 ☐ No maximum

B18. Indicate which of these services were included in the plan.

Check all that apply.

164 ☐ Routine mammograms
165 ☐ Adult routine physical exams
166 ☐ Routine pap smears

167 ☐ Office visits for prenatal care

168 ☐ Adult immunizations
169 ☐ Child immunizations

170 ☐ Well-baby care, under 1 year
171 ☐ Well-child care, 1–4 years
172 ☐ 100% well-baby care

173 ☐ Chiropractic care
174 ☐ Other non-physician providers
175 ☐ Outpatient prescriptions

176 ☐ Routine dental care
177 ☐ Orthodontic care

178 ☐ Nursing home care
179 ☐ Home health care

180 ☐ Inpatient mental illness
181 ☐ Outpatient mental illness
182 ☐ Alcohol/substance abuse treatment

B19. Could this plan have refused to cover persons with certain preexisting conditions?

183 1 ☐ Yes 2 ☐ No

Did this happen in 1996?

184 1 ☐ Yes 2 ☐ No

B20. Could this plan have imposed a waiting period for persons with certain preexisting conditions?

185 1 ☐ Yes 2 ☐ No

Section B – PLAN CHARACTERISTICS – Continued

B21a. Is this plan offered in 1997?

186
1 ☐ Yes – **If Yes, go to Question B21c.**
2 ☐ No

b. If it is not still offered, indicate if it has been –

187
1 ☐ Replaced with a similar plan
2 ☐ Replaced by a substantially different plan
3 ☐ Dropped without offering a replacement – **END THIS FORM.**

B21c. For 1997, enter the single and family enrollments and premiums for this plan or the one that took its place.

Report for the same premium period as in Question B11a on page 2.

188 _____ Single enrollment

189 _____ Family enrollment

190 $ _____.00 Single premium

191 $ _____.00 Family premium

500 Remarks

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

OMB No. 0935-0098: Approval Expires 04/30/98

FORM **MEPS-11(C)**
(7-7-97)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

GOVERNMENT/CERTAINTY QUESTIONNAIRE

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Sections 903(c) and 308(d) of that Act specify that all information will be held in strict confidence by the staff of the Agency for Health Care Policy and Research and their authorized contractors.

RETURN TO ➧ **Bureau of the Census**
Governments Division – MEPS
Washington Plaza II, Rm. 413
Washington, DC 20233-6800

If you have any questions concerning this survey, please call 1–888–206–5068.

Please correct errors in name, address, and ZIP Code. ENTER number and street if not shown.

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

1. For this survey, a **health insurance plan** is defined as providing **hospital and/or physician coverage** for a **single premium** to employees and/or retirees. Exclude extra-cash plans (a specified number of dollars per day in the hospital) or dread-disease (e.g., cancer-only) plans.
2. Coverage could have been purchased from an insurance company, provided by a union or trade association, or self-insured by your governmental unit.
3. **Single and family** plans offered by the same insurance company and providing the same level of hospital and physician benefits count as **one plan**.
4. **High and low** options of a plan offered by the same insurance company count as **two plans**.
5. An **HMO** and a **conventional** plan offered by the same insurance company count as **two plans**.
6. **Estimates** are acceptable if you do not have this information readily available.
7. Provide information for the **pay period that included July 1, 1996** for characteristics such as coverage, premiums, and enrollment. Annual totals, such as costs, should be for **calendar year 1996**, if possible, or for the plan year that included July 1, 1996.

Section A – NUMBER OF PLANS

A1. Did you make available or contribute to the cost of any health insurance plans for your employees or retirees on July 1, 1996? *See instructions 1–5 above for a description of health insurance plans.*

001 1 ☐ Yes ➧ 2 ☐ No – **If No, go to Section C on page 3.**

How many? 003 ☐ ➧

Continue with Section B on page 2.

PLEASE ENCLOSE A COPY OF EACH PLAN BROCHURE WITH YOUR DATA SUBMISSION

Section B – PLAN CHARACTERISTICS

B1. On July 1, 1996, what was the name of the health insurance plan with the highest enrollment and its carrier? For additional plans that you offer, use the Supplemental Sheets (if any) or a copy of this page.

FOR CENSUS USE ONLY

100

012 Name of plan

102 Name of insurance carrier

B2a. For this plan, enter the total number of enrollees excluding dependents for this governmental unit on July 1, 1996.

124

b. Enter the total number of active employees enrolled.

125

c. Enter the number of former employees enrolled through COBRA or other State continuation-of-benefits laws.

126

d. Enter the number of retirees enrolled.

127 Total

128 65 and older

e. Enter the **total** number of enrollees with **single** coverage.

129

B3a. Enter this plan's **total** premium, employer contribution, and employee contribution for a typical full-time employee with **single** coverage.

If self-insured, enter the monthly premium equivalent.

130 $ .00 Total premium

131 $ .00 Employer contribution

132 $ .00 Employee contribution

Indicate the premium period

133 1 ☐ Week 2 ☐ 2 weeks 3 ☐ Month 4 ☐ Year

B3b. Enter this plan's **total** premium, employer contribution, and employee contribution for an enrolled **family** (of four).

Report for the same premium period as in Question B3a.

If self-insured, enter the monthly premium equivalent.

134 $ .00 Total premium

135 $ .00 Employer contribution

136 $ .00 Employee contribution

137 ☐ Family coverage was not offered

B4. Indicate the type of indemnification of this plan.

105

1 ☐ **Purchased** from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses.

2 ☐ **Self-insured** – Your governmental unit pays the claims from its resources and may charge a premium to employees. The plan may be administered by a *third party*. This type may employ supplemental *stop-loss insurance* to limit unanticipated losses.

B5a. Is this plan offered in 1997?

186

1 ☐ Yes – **If Yes, go to Question B5c.**

2 ☐ No

b. If it is not still offered, indicate if it has been –

187

1 ☐ Replaced with a similar plan

2 ☐ Replaced by a substantially different plan

3 ☐ Dropped without offering a replacement – **Go to Section C on page 3.**

c. For 1997, enter the single and family enrollments and premiums for this plan or the one that took its place.

Report for the same premium period as in Question B3a.

188 Single enrollment

189 Family enrollment

190 $ .00 Single premium

191 $ .00 Family premium

Please complete one Supplemental Sheet for each additional hospital/physician plan you offered your employees and retirees on July 1, 1996. You may use photocopies of the Supplemental Sheet or Section B of this form, if necessary.

Control No.

Section C – EMPLOYMENT CHARACTERISTICS

C1. Enter the total annual cost of coverage for the plan year that included July 1, 1996 for **ALL** hospital/physician plans offered by your governmental unit. *Include employer and employee contributions.*

199 $ .00

C2. For the pay period including July 1, 1996, enter the number of employees on your payroll for each of the categories below. Include employees of any dependent agencies associated with your governmental unit. **If you offered health insurance**, also enter the number of employees eligible for coverage and enrolled through your governmental unit and dependent agencies. *Exclude leased or contract workers.*

a. All employees

Total	Eligible	Enrolled
200	201	202

b. Part-time employees

Total	Eligible	Enrolled
203	204	205

c. Temporary (seasonal) employees

Total	Eligible	Enrolled
206	207	208

d. Were retirees eligible to receive health insurance (other than through COBRA or other continuation-of-benefits laws) on July 1, 1996?

219 1 ☐ Yes – *Check all that apply* 2 ☐ No

209 ☐ Retirees under 65 years
210 ☐ Retirees 65 years and over

C3. For the pay period that included July 1, 1996 –

a. Enter the number of women employees 038

b. Enter the number of employees 50 years old or older 039

c. Enter the number of employees who were union members 040

d. Enter the number of employees who earned –

(1) Less than $6.50 per hour 042

(2) Between $6.50 and $15.00 per hour . . . 043

(3) More than $15.00 per hour 044

C4. How many hours per week must an employee work to be considered full time at your governmental unit?

041 Hours

C5. Do you offer any of these fringe benefits?

Check all that apply.

050 ☐ Paid vacation
051 ☐ Paid sick leave
052 ☐ Life insurance
053 ☐ Disability insurance
054 ☐ Retirement/pension plans
055 ☐ Medical Savings Accounts (MSAs)
056 ☐ Flexible spending accounts
057 ☐ Cafeteria plan –

Enter the average annual value per employee → 058 $ .00

500 Remarks

Section D – PERSON COMPLETING THIS QUESTIONNAIRE

212 Name *(Please print)*	213 Title
Signature	214 Date

215 Telephone number ( )	220 Extension	216 FAX number ( )	217 E-Mail address

PLEASE ENCLOSE A COPY OF EACH PLAN BROCHURE WITH YOUR DATA SUBMISSION

OMB No. 0935-0098: Approval Expires 04/30/98

FORM **MEPS-11(CS)** (7-7-97)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

SUPPLEMENTAL SHEET GOVERNMENT/CERTAINTY QUESTIONNAIRE

NOTE – This Supplemental Sheet is a reprint of the questions in Section B of the Government/Certainty Questionnaire (MEPS-11(C)). You may use it to report additional health plan information. You may use photocopies of this Supplemental Sheet if sufficient copies were not included in your reporting package. Refer to the instructions on the first page of the Government/Certainty Questionnaire (MEPS-11(C)) when completing this Supplemental Sheet.

Section B – PLAN CHARACTERISTICS

B1. Enter the name of the health insurance plan and the insurance carrier.

FOR CENSUS USE ONLY

100

012 Name of plan

102 Name of insurance carrier

B2a. For this plan, enter the total number of enrollees excluding dependents for this governmental unit on July 1, 1996.

124

b. Enter the total number of active employees enrolled.

125

c. Enter the number of former employees enrolled through COBRA or other State continuation-of-benefits laws.

126

d. Enter the number of retirees enrolled.

127 Total 128 65 and older

e. Enter the **total** number of enrollees with **single** coverage.

129

B3a. Enter this plan's **total** premium, employer contribution, and employee contribution for a typical full-time employee with **single** coverage.

If self-insured, enter the monthly premium equivalent.

130 $ .00 Total premium

131 $ .00 Employer contribution

132 $ .00 Employee contribution

Indicate the premium period

133 1 ☐ Week 2 ☐ 2 weeks 3 ☐ Month 4 ☐ Year

B3b. Enter this plan's **total** premium, employer contribution, and employee contribution for an enrolled **family** (of four).

Report for the same premium period as in Question B3a.

If self-insured, enter the monthly premium equivalent.

134 $ .00 Total premium

135 $ .00 Employer contribution

136 $ .00 Employee contribution

137 ☐ Family coverage was not offered

B4. Indicate the type of indemnification of this plan.

105

1 ☐ **Purchased** from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses.

2 ☐ **Self-insured** – Your governmental unit pays the claims from its resources and may charge a premium to employees. The plan may be administered by a *third party*. This type may employ supplemental *stop-loss insurance* to limit unanticipated losses.

B5a. Is this plan offered in 1997?

186

1 ☐ Yes – **If Yes, go to Question B5c.**

2 ☐ No

b. If it is not still offered, indicate if it has been –

187

1 ☐ Replaced with a similar plan

2 ☐ Replaced by a substantially different plan

3 ☐ Dropped without offering a replacement – **END THIS FORM.**

c. For 1997, enter the single and family enrollments and premiums for this plan or the one that took its place.

Report for the same premium period as in Question B3a.

188 Single enrollment

189 Family enrollment

190 $ .00 Single premium

191 $ .00 Family premium

If you have any questions concerning this survey, please call 1–888–206–5068.

PLEASE ENCLOSE A COPY OF EACH PLAN BROCHURE WITH YOUR DATA SUBMISSION

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

OMB No. 0935-0098: Approval Expires 04/30/98

FORM **MEPS-11**
(7-7-97)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

GOVERNMENT QUESTIONNAIRE

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Sections 903(c) and 308(d) of that Act specify that all information will be held in strict confidence by the staff of the Agency for Health Care Policy and Research and their authorized contractors.

RETURN TO **Bureau of the Census**
1201 East 10th Street
Jeffersonville, IN 47132-0001

If you have any questions concerning this survey, please call 1–888–273–3878.

Please correct errors in name, address, and ZIP Code. ENTER number and street if not shown.

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

1. For this survey, a **health insurance plan** is defined as providing **hospital and/or physician coverage** for a **single premium** to employees and/or retirees. Exclude extra-cash plans (a specified number of dollars per day in the hospital) or dread-disease (e.g., cancer-only) plans.
2. Coverage could have been purchased from an insurance company, provided by a union or trade association, or self-insured by your governmental unit.
3. **Single and family** plans offered by the same insurance company and providing the same level of hospital and physician benefits count as **one plan**.
4. **High and low** options of a plan offered by the same insurance company count as **two plans**.
5. An **HMO** and a **conventional** plan offered by the same insurance company count as **two plans**.
6. For the deductibles, copayments, and premiums, **report for typical situations and enrollees**. If cost varies by family size, use a **family of four**. If cost varies by age, provide the information for the average age of your workers.
7. **Estimates** are acceptable if you do not have this information readily available.
8. Provide information for the **pay period that included July 1, 1996** for characteristics such as coverage, premiums, and enrollment. Annual totals, such as costs, should be for **calendar year 1996**, if possible, or for the plan year that included July 1, 1996.

Section A – NUMBER OF PLANS

A1. Did you make available or contribute to the cost of any health insurance plans for your employees or retirees on July 1, 1996? *See instructions 1–5 above for a description of health insurance plans.*

001 1 ☐ Yes ↙ 2 ☐ No – **If No, go to Section D on page 5.**

003 **How many?** ☐ ↙

Continue with Section B on page 2.

Section B – PLAN CHARACTERISTICS

B1. On July 1, 1996, what was the name of the health insurance plan with the highest enrollment and its carrier? For additional plans that you offer, use the Supplemental Sheets (if any) or a copy of Section B of this form.

FOR CENSUS USE ONLY

100

012 Name of plan

102 Name of insurance carrier

B2. Indicate the type of providers in this plan.

103

1 ☐ **Exclusive providers** – Enrollees must go to providers associated with the plan except in an emergency. There is typically no cost or a small fixed cost for each physician visit. (For example, HMOs, IPAs, EPOs)

2 ☐ **Any providers** – Enrollees can go to the physicians of their choice on a fee-for-service basis. The plan does not have any associated providers. (For example, conventional plans, indemnity plans)

3 ☐ **Mixture of preferred and any providers** – Enrollees can go to a set of "preferred" providers associated with the plan, or providers of their choice. If they go to a non-preferred provider, they face higher costs. (For example, PPOs, POSs)

B3. Did this plan **require** that the enrollee see a primary-care physician in order to be referred to a specialist?

104 1 ☐ Yes 2 ☐ No

B4. Indicate the type of indemnification of this plan.

105

1 ☐ **Purchased** from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses.

If purchased, go to Question B6.

2 ☐ **Self-insured** – Your governmental unit pays the claims from its resources and may charge a premium to employees. The plan may be administered by a *third party*. This type may employ supplemental *stop-loss insurance* to limit unanticipated losses.

For self-insured plans only:

B5a. Indicate if you administered the plan or if you employed a third party.

106

1 ☐ Self-administered

2 ☐ Insurance company or other administrator

b. Did you purchase stop-loss coverage?

107 1 ☐ Yes 2 ☐ No

B5c. Enter this governmental unit's **total annual cost** of coverage for this plan for the plan year that included July 1, 1996. Include: claims paid, administrative costs, and stop-loss coverage (if any). Include employer and employee contributions.

108 $ .00 *If this is the only plan you offered, also enter this amount in Question C3 on page 4.*

d. Enter the **monthly premium equivalents** (or the COBRA amount if premium equivalents were not calculated) for single and family (of four) coverage for a typical full-time employee. Include the costs entered in B5c. *Also enter this information in Question B10a (single) and B10b (family) – Total premium on page 3.*

109 $ .00 Single coverage

110 $ .00 Family coverage

e. Is the amount entered in B5d –

111

1 ☐ A premium equivalent?

2 ☐ A COBRA amount?

B6. Was this plan operated by a –

113 1 ☐ Union ↙ 2 ☐ Trade Association ↙ 3 ☐ Neither

114 Name of union or trade association	115 Local number, if a union

116 Name of insurance representative

117 Address *(Number and street)*

118 City	119 State	120 ZIP Code

121 Telephone number

( )

B7. Did any enrollee receive a direct subsidy or contribution towards any part of the premium (e.g., from a union)?

122 1 ☐ Yes 2 ☐ No

B8. In what month did the plan year begin?

Enter a numeric response (e.g., Jan = 01, May = 05). 123 ☐☐ Month

Control No.

Section B – PLAN CHARACTERISTICS – Continued

B9a. For this plan, enter the total number of enrollees excluding dependents for this governmental unit on July 1, 1996.

124 ☐

b. Enter the total number of active employees enrolled.

125 ☐

c. Enter the number of former employees enrolled through COBRA or other State continuation-of-benefits laws.

126 ☐

d. Enter the number of retirees enrolled.

127 ☐ Total 128 ☐ 65 and older

e. Enter the **total** number of enrollees with **single** coverage.

129 ☐

B10a. Enter this plan's **total** premium, employer contribution, and employee contribution for a typical full-time employee with **single** coverage.

If self-insured, enter the monthly premium equivalent from Question B5d on page 2.

130 $ .00 Total premium

131 $ .00 Employer contribution

132 $ .00 Employee contribution

Indicate the premium period ↙

133 1 ☐ Week 2 ☐ 2 weeks 3 ☐ Month 4 ☐ Year

b. Enter this plan's **total** premium, employer contribution, and employee contribution for an enrolled **family** (of four).

Report for the same premium period as in B10a.

If self-insured, enter the monthly premium equivalent from Question B5d on page 2.

134 $ .00 Total premium

135 $ .00 Employer contribution

136 $ .00 Employee contribution

137 ☐ Family coverage was not offered

B11a. Did the **premiums** (not contributions) vary by –

Check all that apply.

138 ☐ Age?
139 ☐ Sex?
140 ☐ Number of persons (within family coverage)?
141 ☐ Wage or salary levels?
142 ☐ Other? – *Specify*
099 ☐

B11b. Did the **amount of the employee contribution** (not premium) vary for different employee categories (e.g., full-time, part-time, retiree)?

143 1 ☐ Yes 2 ☐ No

B12. Did this plan's **premium** include either of these services?

Check all that apply.

144 ☐ Life insurance 145 ☐ Disability insurance

B13. Enter the **annual deductibles** that enrollees paid out of their pockets before the plan began paying for covered services (using the plan's providers). Many HMO-type plans do not have deductibles.

146 $ .00 **Total individual annual deductible OR** ↙

Separate deductibles for:

147 $ .00 Physician care

148 $ .00 Hospital care

If the deductible is per overnight hospital stay, report under B14a.

149 $ .00 **Total family annual deductible** *(if applicable)* ↙

150 ☐ Number of persons – *Enter if the plan also specified that the family deductible was met when a number of family members fulfilled their individual deductibles.*

151 ☐ Plan did not have a deductible

B14a. How much did an **enrollee** pay for an **overnight hospital stay** (in a participating hospital, if applicable) after any annual deductible was met?

152 $ .00 → 154 1 ☐ Per day 2 ☐ Per stay

OR

153 ☐ Percent **OR**

155 ☐ Hospital care was not covered

b. How much did an **enrollee** pay for an **office visit** (with a participating physician, if applicable) after any annual deductible was met?

156 $ .00

OR

157 ☐ Percent **OR**

218 ☐ Physician care was not covered

B15. What was the maximum amount this plan would have paid for an individual –

a. Over the enrollee's lifetime?

159 $ .00

b. In one year?

160 $ .00

158 ☐ No maximum

Section B – PLAN CHARACTERISTICS – Continued

B16. What was the maximum annual out-of-pocket amount for –

a. An individual?

161 $ .00

b. A family (of four)?

162 $ .00

163 ☐ No maximum

B17. Indicate which of these services were included in the plan.

Check all that apply.

164 ☐ Routine mammograms
165 ☐ Adult routine physical exams
166 ☐ Routine pap smears

167 ☐ Office visits for prenatal care

168 ☐ Adult immunizations
169 ☐ Child immunizations

170 ☐ Well-baby care, under 1 year
171 ☐ Well-child care, 1–4 years
172 ☐ 100% well-baby care

173 ☐ Chiropractic care
174 ☐ Other non-physician providers
175 ☐ Outpatient prescriptions

176 ☐ Routine dental care
177 ☐ Orthodontic care

178 ☐ Nursing home care
179 ☐ Home health care

180 ☐ Inpatient mental illness
181 ☐ Outpatient mental illness
182 ☐ Alcohol/substance abuse treatment

B18. Could this plan have refused to cover persons with certain preexisting conditions?

183 1 ☐ Yes ↙ 2 ☐ No

Did this happen in 1996?

184 1 ☐ Yes 2 ☐ No

B19. Could this plan have imposed a waiting period for persons with certain preexisting conditions?

185 1 ☐ Yes 2 ☐ No

B20a. Is this plan offered in 1997?

186 1 ☐ Yes – **If Yes, go to Question B20c.**
2 ☐ No

b. If it is not still offered, indicate if it has been –

187 1 ☐ Replaced with a similar plan
2 ☐ Replaced by a substantially different plan
3 ☐ Dropped without offering a replacement – **Go to Section C.**

c. For 1997, enter the single and family enrollments and premiums for this plan or the one that took its place.

Report for the same premium period as in Question B10a on page 3.

188 ☐ Single enrollment

189 ☐ Family enrollment

190 $ .00 Single premium

191 $ .00 Family premium

Please complete one Supplemental Sheet for each additional hospital/physician plan you offered your employees and retirees on July 1, 1996. You may use photocopies of the Supplemental Sheet or Section B of this form, if necessary.

Section C – GENERAL HEALTH COVERAGE CHARACTERISTICS

C1a. Did you offer **optional** coverage (not included in the basic health coverage) for any of these services in 1996 at an additional premium to the employee?

Check all that apply.

192 ☐ Dental
193 ☐ Vision
194 ☐ Prescription drugs
195 ☐ Long-term care

b. What was the total amount paid for these coverages in 1996? *Include employer and employee contributions.*

196 $ .00

C2a. Did you impose a waiting period before new employees could be covered by health insurance?

197 1 ☐ Yes ↙ 2 ☐ No

b. What was the typical waiting period?

198 1 ☐ Less than 2 weeks
2 ☐ 2 weeks to less than 1 month
3 ☐ 1–3 months
4 ☐ More than 3 months

C3. Enter the total annual cost of coverage for the plan year that included July 1, 1996 for **ALL** hospital/physician plans offered by your governmental unit. *Include employer and employee contributions.*

199 $ .00

Control No.

Section D – EMPLOYMENT CHARACTERISTICS

D1. For the pay period including July 1, 1996, enter the number of employees on your payroll for each of the categories below. Include employees of any dependent agencies associated with your governmental unit. **If you offered health insurance**, also enter the number of employees eligible and enrolled for coverage through your governmental unit and dependent agencies. *Exclude leased or contract workers.*

a. All employees

Total	Eligible	Enrolled
200	201	202

b. Part-time employees

Total	Eligible	Enrolled
203	204	205

c. Temporary (seasonal) employees

Total	Eligible	Enrolled
206	207	208

d. Were retirees eligible to receive health insurance (other than through COBRA or other continuation-of-benefits laws) on July 1, 1996?

219 1 ☐ Yes – *Check all that apply* ↙ 2 ☐ No

209 ☐ Retirees under 65 years
210 ☐ Retirees 65 years and over

D2. For the pay period that included July 1, 1996 –

a. Enter the number of women employees 038

b. Enter the number of employees 50 years old or older 039

D2c. Enter the number of employees who were union members 040

d. Enter the number of employees who earned –

(1) Less than $6.50 per hour 042

(2) Between $6.50 and $15.00 per hour . . . 043

(3) More than $15.00 per hour 044

D3. How many hours per week must an employee work to be considered full time at your governmental unit?

041 ☐ Hours

D4. Do you offer any of these fringe benefits?

Check all that apply.

050 ☐ Paid vacation
051 ☐ Paid sick leave
052 ☐ Life insurance
053 ☐ Disability insurance
054 ☐ Retirement/pension plans
055 ☐ Medical Savings Accounts (MSAs)
056 ☐ Flexible spending accounts

057 ☐ Cafeteria plan –

Enter the average annual value per employee → 058 $ .00

500 Remarks

Section E – PERSON COMPLETING THIS QUESTIONNAIRE

212 Name *(Please print)*	213 Title
Signature	214 Date

215 Telephone number ( )	220 Extension	216 FAX number ( )	217 E-Mail address

OMB No. 0935-0098: Approval Expires 04/30/98

FORM **MEPS-11(P)**
(7-7-97)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

PERSON-LEVEL QUESTIONNAIRE FOR GOVERNMENTAL UNITS

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Sections 903(c) and 308(d) of that Act specify that all information will be held in strict confidence by the staff of the Agency for Health Care Policy and Research and their authorized contractors.

RETURN TO

If you have any questions concerning this survey, please call

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

1. In this questionnaire, "this person" refers to the individual named in the label area. A permission slip signed by the individual authorizing our collection of this information is included at the back of the reporting package.

2. For this survey, **a health insurance plan** is defined as providing **hospital and/or physician coverage** for a **single premium** to employees and/or retirees. Also included in Section C of this questionnaire are single-service plans, which provide optional coverage not included in the basic health insurance plan(s) for an additional premium.

Section A – PERSON–LEVEL INFORMATION

A1. Which category below **best** describes this person's status with your governmental unit on July 1, 1996?

Check only ONE.

065
1 ☐ A full- or part-time employee
2 ☐ A retiree
3 ☐ A former employee
4 ☐ A relative/survivor of a former employee
5 ☐ A seasonal or temporary employee

Go to Section B on page 2.

6 ☐ An employee of a temporary agency
7 ☐ An independent contract worker
8 ☐ No record of this person

Go to Section D on page 3.

Section B – HOSPITAL OR PHYSICIAN PLAN

B1a. Was this person **eligible** for hospital/physician insurance coverage through your governmental unit on July 1, 1996?

350 1 ☐ Yes ↙ 2 ☐ No – **If No, go to Section C on page 3.**

If more than one plan was offered through this governmental unit, answer Part b below. If only one plan was offered, go to Question B2a.

b. Of the hospital/physician plans offered by your governmental unit, for which plans was this person eligible?

Please enter plan name(s) exactly as entered in Question B1 of the Governmental Questionnaire (MEPS-11) or Supplemental Sheet (MEPS-11(S)).

351 ☐ All **OR** ↙

501 _____

502 _____

503 _____

504 _____

B2a. Was this person **enrolled** in a hospital/physician plan provided by your governmental unit on July 1, 1996?

231 1 ☐ Yes ↙ 2 ☐ No – **If No, go to Section C on page 3.**

If more than one plan was offered through this governmental unit, answer Part b below. If only one plan was offered, go to Question B3.

b. In which hospital/physician plan(s) was this person enrolled?

Please enter plan name(s) exactly as entered in Question B1 of the Governmental Questionnaire (MEPS-11) or Supplemental Sheet (MEPS-11(S)).

352 ☐ All **OR** ↙

021 _____

505 _____

B3. What level of coverage did this person choose?

239 1 ☐ Single 3 ☐ One adult/one child
2 ☐ Two adults 4 ☐ Family (3 or more people)

B4. For the pay period including July 1, 1996, provide the information below regarding premiums paid for this person's hospital/physician coverage.

a. What was the **total premium including both employer and employee contributions?**

If this plan was self-insured, *enter the monthly premium equivalent. If a premium equivalent was not calculated, enter the COBRA amount.*

361 $ .00 PER → 376 1 ☐ Week
2 ☐ 2 weeks
3 ☐ Month
4 ☐ Year

b. How much did **this person contribute** towards his/her coverage?

Report for the same premium period as in Question B4a.

362 $ .00

OR

353 ☐ Percent of insurance premium

c. How much did **your governmental unit contribute** towards this person's coverage?

Report for the same premium period as in Question B4a.

363 $ .00

OR

354 ☐ Percent of insurance premium

d. How much did sources other than your governmental unit, such as a union, contribute towards/subsidize this person's coverage?

Report for the same premium period as in Question B4a.

355 $ .00

OR

356 ☐ Percent of insurance premium

OR

357 ☐ No subsidy/contribution from other sources – **Go to Question B6.**

B5. What was the source of the outside subsidy or contribution reported in B4d?

Check only ONE.

358 1 ☐ Union
3 ☐ Other

B6. Was this person's insurance provided through COBRA?

359 1 ☐ Yes 2 ☐ No

Control No.

Section C – SINGLE-SERVICE PLANS

C1. On July 1, 1996, did this person obtain through your governmental unit any optional coverage (not included in his/her basic health plan reported in Section B above) at an additional premium?

246 1 ☐ Yes 2 ☐ No – **If No, go to Section D.**

C2. Which of the following single-service plans did this person obtain?

Check all that apply.

370 ☐ Dental
372 ☐ Vision
371 ☐ Prescription drugs
373 ☐ Long-term care

C3a. What was the total premium for all single-service plans obtained by this person, including employer and employee contributions?

374 $ .00 PER →

380 1 ☐ Week
2 ☐ 2 weeks
3 ☐ Month
4 ☐ Year

b. How much did **this person contribute** towards his/her single-service plan coverage?

Report for the same premium period as in Question C3a.

375 $ .00

OR

360 ☐ Percent of insurance premium

500 Remarks

Section D – PERSON COMPLETING THIS QUESTIONNAIRE

212 Name *(Please print)*	213 Title
Signature	214 Date

215 Telephone number ( )	220 Extension	216 FAX number ( )	217 E-Mail address

OMB No. 0935-0098: Approval Expires 04/30/98

FORM **MEPS-11(S)**
(7-7-97)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

SUPPLEMENTAL SHEET GOVERNMENT QUESTIONNAIRE

INSTRUCTIONS

This Supplemental Sheet is a reprint of the questions in Section B of the Government Questionnaire (MEPS-11). You may use it to report additional health plan information. You may use photocopies of this Supplemental Sheet if sufficient copies were not included in your reporting package. Refer to the instructions on the first page of the Government Questionnaire (MEPS-11) when completing this Supplemental Sheet.

Section B – PLAN CHARACTERISTICS

B1. Enter the name of the health insurance plan and the insurance carrier.

FOR CENSUS USE ONLY

100

012 Name of plan

102 Name of insurance carrier

B2. Indicate the type of providers in this plan.

103
1 ☐ **Exclusive providers** – Enrollees must go to providers associated with the plan except in an emergency. There is typically no cost or a small fixed cost for each physician visit. (For example, HMOs, IPAs, EPOs)

2 ☐ **Any providers** – Enrollees can go to the physicians of their choice on a fee-for-service basis. The plan does not have any associated providers. (For example, conventional plans, indemnity plans)

3 ☐ **Mixture of preferred and any providers** – Enrollees can go to a set of "preferred" providers associated with the plan, or providers of their choice. If they go to a non-preferred provider, they face higher costs. (For example, PPOs, POSs)

B3. Did this plan **require** that the enrollee see a primary-care physician in order to be referred to a specialist?

104 1 ☐ Yes 2 ☐ No

B4. Indicate the type of indemnification of this plan.

105
1 ☐ **Purchased** from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses.

If purchased, go to Question B6 on page 2.

2 ☐ **Self-insured** – Your governmental unit pays the claims from its resources and may charge a premium to employees. The plan may be administered by a *third party*. This type may employ supplemental *stop-loss insurance* to limit unanticipated losses.

For self-insured plans only:

B5a. Indicate if you administered the plan or if you employed a third party.

106
1 ☐ Self-administered
2 ☐ Insurance company or other administrator

b. Did you purchase stop-loss coverage?

107 1 ☐ Yes 2 ☐ No

c. Enter this governmental unit's **total annual cost** of coverage for this plan for the plan year that included July 1, 1996. Include: claims paid, administrative costs, and stop-loss coverage (if any). Include employer and employee contributions.

108 $ .00

d. Enter the **monthly premium equivalents** (or the COBRA amount if premium equivalents were not calculated) for single and family (of four) coverage for a typical full-time employee. Include the costs entered in B5c. *Also enter this information in Question B10a (single) and B10b (family) – Total premium on page 2.*

109 $ .00 Single coverage

110 $ .00 Family coverage

e. Is the amount entered in B5d –

111
1 ☐ A premium equivalent?
2 ☐ A COBRA amount?

Section B – PLAN CHARACTERISTICS – Continued

B6. Was this plan operated by a –

113 1 ☐ Union ↙ 2 ☐ Trade Association ↙ 3 ☐ Neither

114 Name of union or trade association	115 Local number, if a union

116 Name of insurance representative

117 Address *(Number and street)*

118 City	119 State	120 ZIP Code

121 Telephone number

( )

B7. Did any enrollee receive a direct subsidy or contribution towards any part of the premium (e.g., from a union)?

122 1 ☐ Yes 2 ☐ No

B8. In what month did the plan year begin?

Enter a numeric response (e.g., Jan = 01, May = 05). 123 ☐☐ Month

B9a. For this plan, enter the total number of enrollees excluding dependents for this governmental unit on July 1, 1996.

124 ☐☐☐☐☐

b. Enter the total number of active employees enrolled.

125 ☐☐☐☐☐

c. Enter the number of former employees enrolled through COBRA or other State continuation-of-benefits laws.

126 ☐☐☐☐☐

d. Enter the number of retirees enrolled.

127 ☐☐☐☐☐ Total 128 ☐☐☐☐☐ 65 and older

e. Enter the **total** number of enrollees with **single** coverage.

129 ☐☐☐☐☐

B10a. Enter this plan's **total** premium, employer contribution and employee contribution for a typical full-time employee with **single** coverage.

If self-insured, enter the monthly premium equivalent from Question B5d on page 1.

130 $ .00 Total premium

131 $ .00 Employer contribution

132 $ .00 Employee contribution

Indicate the premium period ↙

133 1 ☐ Week 2 ☐ 2 weeks 3 ☐ Month 4 ☐ Year

b. Enter this plan's **total** premium, employer contribution and employee contribution for an enrolled **family** (of four).

Report for the same premium period as in Question B10a.

If self-insured, enter the monthly premium equivalent from Question B5d on page 1.

134 $ .00 Total premium

135 $ .00 Employer contribution

136 $ .00 Employee contribution

137 ☐ Family coverage was not offered

B11a. Did the **premiums** (not contributions) vary by –

Check all that apply.

138 ☐ Age?
139 ☐ Sex?
140 ☐ Number of persons (within family coverage)?
141 ☐ Wage or salary levels?
142 ☐ Other? – *Specify*
099 ☐☐☐☐☐

b. Did the **amount of the employee contribution** (not premium) vary for different employee categories (e.g., full-time, part-time, retiree)?

143 1 ☐ Yes 2 ☐ No

B12. Did this plan's **premium** include either of these services?

Check all that apply.

144 ☐ Life insurance 145 ☐ Disability insurance

Control No.

Section B – PLAN CHARACTERISTICS – Continued

B13. Enter the **annual deductibles** that enrollees paid out of their pockets before the plan began paying for covered services (using the plan's providers). Many HMO-type plans do not have deductibles.

146 $ .00 **Total individual annual deductible OR**

Separate deductibles for:

147 $ .00 Physician care

148 $ .00 Hospital care

If the deductible is per overnight hospital stay, report under B14a.

149 $ .00 **Total family annual deductible** *(if applicable)*

150 ☐ Number of persons – *Enter if the plan also specified that the family deductible was met when a number of family members fulfilled their individual deductibles.*

151 ☐ Plan did not have a deductible

B14a. How much did an **enrollee** pay for an **overnight hospital stay** (in a participating hospital, if applicable) after any annual deductible was met?

152 $ .00 → 154 1 ☐ Per day 2 ☐ Per stay

OR

153 ☐ Percent

OR

155 ☐ Hospital care was not covered

b. How much did an **enrollee** pay for an **office visit** (with a participating physician, if applicable) after any annual deductible was met?

156 $ .00

OR

157 ☐ Percent

OR

218 ☐ Physician care was not covered

B15. What was the maximum amount this plan would have paid for an individual –

a. Over the enrollee's lifetime?

159 $ .00

b. In one year?

160 $ .00

158 ☐ No maximum

B16. What was the maximum annual out-of-pocket amount for –

a. An individual?

161 $ .00

b. A family (of four)?

162 $ .00

163 ☐ No maximum

B17. Indicate which of these services were included in the plan.

Check all that apply.

164 ☐ Routine mammograms
165 ☐ Adult routine physical exams
166 ☐ Routine pap smears

167 ☐ Office visits for prenatal care

168 ☐ Adult immunizations
169 ☐ Child immunizations

170 ☐ Well-baby care, under 1 year
171 ☐ Well-child care, 1–4 years
172 ☐ 100% well-baby care

173 ☐ Chiropractic care
174 ☐ Other non-physician providers
175 ☐ Outpatient prescriptions

176 ☐ Routine dental care
177 ☐ Orthodontic care

178 ☐ Nursing home care
179 ☐ Home health care

180 ☐ Inpatient mental illness
181 ☐ Outpatient mental illness
182 ☐ Alcohol/substance abuse treatment

B18. Could this plan have refused to cover persons with certain preexisting conditions?

183 1 ☐ Yes 2 ☐ No

Did this happen in 1996?

184 1 ☐ Yes 2 ☐ No

B19. Could this plan have imposed a waiting period for persons with certain preexisting conditions?

185 1 ☐ Yes 2 ☐ No

Section B – PLAN CHARACTERISTICS – Continued

B20a. Is this plan offered in 1997?

186 1 ☐ Yes – **If Yes, go to Question B20c.**
2 ☐ No

b. If it is not still offered, indicate if it has been –

187 1 ☐ Replaced with a similar plan
2 ☐ Replaced by a substantially different plan
3 ☐ Dropped without offering a replacement – **END THIS FORM.**

B20c. For 1997, enter the single and family enrollments and premiums for this plan or the one that took its place.

Report for the same premium period as in Question B10a on page 2.

188 _____ Single enrollment

189 _____ Family enrollment

190 $ _____.00 Single premium

191 $ _____.00 Family premium

500 Remarks

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

OMB No. 0935-0098: Approval Expires 04/30/98

FORM **MEPS-12**
(7-7-97)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

UNION QUESTIONNAIRE

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Sections 903(c) and 308(d) of that Act specify that all information will be held in strict confidence by the staff of the Agency for Health Care Policy and Research and their authorized contractors.

RETURN TO **Bureau of the Census**
1201 East 10th Street
Jeffersonville, IN 47132-0001

If you have any questions concerning this survey, please call 1–888–273–3878.

Please correct errors in name, address, and ZIP Code. ENTER number and street if not shown.

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

1. For this survey, a **health insurance plan** is defined as providing **hospital and/or physician coverage** for a **single premium** to members and/or retirees. Exclude extra-cash plans (a specified number of dollars per day in the hospital) or dread-disease (e.g., cancer-only) plans.
2. Coverage could have been purchased from an insurance company or self-insured by your union.
3. **Single and family** plans offered by the same insurance company and providing the same level of hospital and physician benefits count as **one plan**.
4. **High and low** options of a plan offered by the same insurance company count as **two plans**.
5. An **HMO** and a **conventional** plan offered by the same insurance company count as **two plans**.
6. If your union operates at more than one location, provide information for the location on the label unless otherwise directed.
7. For the deductibles, copayments, and premiums, **report for typical situations and enrollees**. If cost varies by family size, use a **family of four**. If cost varies by age, provide the information for the average age of your members.
8. **Estimates** are acceptable if you do not have this information readily available.
9. Provide information for the **pay period that included July 1, 1996** for characteristics such as coverage, premiums, and enrollment. Annual totals, such as costs, should be for **calendar year 1996**, if possible, or for the plan year that included July 1, 1996.

Section A – NUMBER OF PLANS

A1. Did one or more of the individuals named in the label area of the accompanying Person-Level Questionnaire(s) (MEPS-12(P)) receive health insurance coverage through your union on July 1, 1996? *See instructions 1–5 above for a description of health insurance plans?*

001 1 ☐ Yes 2 ☐ No – **If No, go to Section D on page 5.**

A2. How many different health insurance plans did you offer your members or retirees on July 1, 1996?

003 ☐ Number of plans. *See instructions 1–5 above for a description of health insurance plans* – **Continue with Section B on page 2.**

Section B – PLAN CHARACTERISTICS

B1. On July 1, 1996, what was the name of the health insurance plan with the highest enrollment and its carrier?

If you have received Supplemental Sheets (Form MEPS-12(S)) with plan names preprinted in Question B1, answer only for the preprinted plans. Otherwise, provide data for your 4 largest plans. You may make a copy of the Supplemental Sheet, or Section B of this form, if necessary.

FOR CENSUS USE ONLY

100

012 Name of plan

102 Name of insurance carrier

B2. Indicate the type of providers in this plan.

103

1 ☐ **Exclusive providers** – Enrollees must go to providers associated with the plan except in an emergency. There is typically no cost or a small fixed cost for each physician visit. (For example, HMOs, IPAs, EPOs)

2 ☐ **Any providers** – Enrollees can go to the physicians of their choice on a fee-for-service basis. The plan does not have any associated providers. (For example, conventional plans, indemnity plans)

3 ☐ **Mixture of preferred and any providers** – Enrollees can go to a set of "preferred" providers associated with the plan, or providers of their choice. If they go to a non-preferred provider, they face higher costs. (For example, PPOs, POSs)

B3. Did this plan **require** that the enrollee see a primary-care physician in order to be referred to a specialist?

104 1 ☐ Yes 2 ☐ No

B4. Indicate the type of indemnification of this plan.

105

1 ☐ **Purchased** from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses.

If purchased, go to Question B6.

2 ☐ **Self-insured** – Your union pays the claims from its resources and may charge a premium to members. The plan may be administered by a *third party*. This type may employ supplemental *stop-loss insurance* to limit unanticipated losses.

For self-insured plans only:

B5a. Indicate if you administered the plan or if you employed a third party.

106

1 ☐ Self-administered

2 ☐ Insurance company or other administrator

B5b. Did you purchase stop-loss coverage?

107 1 ☐ Yes 2 ☐ No

c. Enter this union's **total annual cost** of coverage for this plan for the plan year that included July 1, 1996. Include: claims paid, administrative costs, and stop-loss coverage (if any). Include union and member contributions.

108 $ .00 *If this is the only plan you offered, also enter this amount in Question C3 on page 4.*

d. Enter the **monthly premium equivalents** for single and family (of four) coverage for a typical member. Include the costs entered in B5c. *Also enter this information in Question B9a (single) and B9b (family) – Total premium on page 3.*

109 $ .00 Single coverage

110 $ .00 Family coverage

B6. Did any enrollee receive a direct subsidy or contribution towards any part of the premium (e.g., from a government or employer)?

122 1 ☐ Yes 2 ☐ No

B7. In what month did the plan year begin?

Enter a numeric response (e.g., Jan = 01, May = 05). 123 ☐☐ Month

B8a. For this plan, enter the total number of enrollees excluding dependents for this union on July 1, 1996.

124

b. Enter the total number of active members enrolled.

125

c. Enter the number of retirees enrolled.

127 Total 128 65 and older

d. Enter the **total** number of enrollees with **single** coverage.

129

Section B – PLAN CHARACTERISTICS – Continued

B9a. Enter this plan's **total** premium, union contribution, and member contribution for an enrollee with **single** coverage.

If self-insured, enter the monthly premium equivalent from Question B5d on page 2.

130 $ .00 Total premium

131 $ .00 Union contribution

132 $ .00 Member contribution

Indicate the premium period

133 1 ☐ Week 2 ☐ 2 weeks 3 ☐ Month 4 ☐ Year

b. Enter this plan's **total** premium, union contribution, and member contribution for an enrolled **family** (of four).

Report for the same premium period as in Question B9a.

If self-insured, enter the monthly premium equivalent from Question B5d on page 2.

134 $ .00 Total premium

135 $ .00 Union contribution

136 $ .00 Member contribution

137 ☐ Family coverage was not offered

B10a. Did the **premiums** (not contributions) vary by –

Check all that apply.

138 ☐ Age?
139 ☐ Sex?
140 ☐ Number of persons (within family coverage)?
142 ☐ Other? – *Specify*
099

b. Did the **amount of the member contribution** (not premium) vary for different member categories (e.g., full-time, part-time, seniority, work site, occupation)?

143 1 ☐ Yes 2 ☐ No

B11. Did this plan's **premium** include either of these services?

Check all that apply.

144 ☐ Life insurance 145 ☐ Disability insurance

B12. Enter the **annual deductibles** that enrollees paid out of their pockets before the plan began paying for covered services (using the plan's providers). Many HMO-type plans do not have deductibles.

146 $ .00 **Total individual annual deductible OR**

Separate deductibles for:

147 $ .00 Physician care

148 $ .00 Hospital care

If the deductible is per overnight hospital stay, report under B13a.

149 $ .00 **Total family annual deductible** *(if applicable)*

150 Number of persons – *Enter if the plan also specified that the family deductible was met when a number of family members fulfilled their individual deductibles.*

151 ☐ Plan did not have a deductible

B13a. How much did an **enrollee** pay for an **overnight hospital stay** (in a participating hospital, if applicable) after any annual deductible was met?

152 $ .00 → 154 1 ☐ Per day 2 ☐ Per stay

OR

153 Percent

OR

155 ☐ Hospital care was not covered

b. How much did an **enrollee** pay for an **office visit** (with a participating physician, if applicable) after any annual deductible was met?

156 $ .00

OR

157 Percent

OR

218 ☐ Physician care was not covered

B14. What was the maximum amount this plan would have paid for an individual –

a. Over the enrollee's lifetime?

159 $ .00

b. In one year?

160 $ .00

158 ☐ No maximum

Section B – PLAN CHARACTERISTICS – Continued

B15. What was the maximum annual out-of-pocket amount for –

a. An individual?

161 $ .00

b. A family (of four)?

162 $ .00

163 ☐ No maximum

B16. Indicate which of these services were included in the plan.

Check all that apply.

164 ☐ Routine mammograms
165 ☐ Adult routine physical exams
166 ☐ Routine pap smears

167 ☐ Office visits for prenatal care

168 ☐ Adult immunizations
169 ☐ Child immunizations

170 ☐ Well-baby care, under 1 year
171 ☐ Well-child care, 1–4 years
172 ☐ 100% well-baby care

173 ☐ Chiropractic care
174 ☐ Other non-physician providers
175 ☐ Outpatient prescriptions

176 ☐ Routine dental care
177 ☐ Orthodontic care

178 ☐ Nursing home care
179 ☐ Home health care

180 ☐ Inpatient mental illness
181 ☐ Outpatient mental illness
182 ☐ Alcohol/substance abuse treatment

B17. Could this plan have refused to cover persons with certain preexisting conditions?

183 1 ☐ Yes ↙ 2 ☐ No

Did this happen in 1996?

184 1 ☐ Yes 2 ☐ No

B18. Could this plan have imposed a waiting period for persons with certain preexisting conditions?

185 1 ☐ Yes 2 ☐ No

B19a. Is this plan offered in 1997?

186 1 ☐ Yes – **If Yes, go to Question B19c.**
2 ☐ No

b. If it is not still offered, indicate if it has been –

187 1 ☐ Replaced with a similar plan
2 ☐ Replaced by a substantially different plan
3 ☐ Dropped without offering a replacement – **Go to Section C.**

c. For 1997, enter the single and family enrollments and premiums for this plan or the one that took its place.

Report for the same premium period as in Question B9a on page 3.

188 ☐ Single enrollment

189 ☐ Family enrollment

190 $ .00 Single premium

191 $ .00 Family premium

Please complete one Supplemental Sheet for each additional hospital/physician plan you offered your members and retirees on July 1, 1996. You may use photocopies of the Supplemental Sheet or Section B of this form, if necessary.

Section C – GENERAL HEALTH COVERAGE CHARACTERISTICS

C1a. Did you offer **optional** coverage (not included in the basic health coverage) for any of these services in 1996 at an additional premium to the member?

Check all that apply.

192 ☐ Dental
193 ☐ Vision
194 ☐ Prescription drugs
195 ☐ Long-term care

b. What was the total amount paid for these coverages in 1996? *Include union and member contributions.*

196 $ .00

C2a. Did you impose a waiting period before new members could be covered by health insurance?

197 1 ☐ Yes ↙ 2 ☐ No – **If No, go to Question C3.**

b. What was the typical waiting period?

198 1 ☐ Less than 2 weeks
2 ☐ 2 weeks to less than 1 month
3 ☐ 1–3 months
4 ☐ More than 3 months

C3. Enter the total annual cost of coverage for the plan year that included July 1, 1996 for **ALL** hospital and physician plans that you offered **at this location**. *Include union and member contributions.*

199 $ .00

Control No.

Section D – UNION CHARACTERISTICS

D1. Enter the number of members in your union at the location period on the label for the period that included July 1, 1996. **If you offered health insurance**, also enter the number of members eligible and enrolled for coverage through your union.

a. All members

	Total	Eligible	Enrolled
	200	201	202

b. Were retirees eligible to receive health insurance on July 1, 1996?

219 1 ☐ Yes – *Check all that apply* 2 ☐ No

209 ☐ Retirees under 65 years
210 ☐ Retirees 65 years and over

D2. For the period that included July 1, 1996 –

a. Enter the number of women members 038

b. Enter the number of members 50 years old or older 039

c. Enter the number of members who earned –

(1) Less than $6.50 per hour 042

(2) Between $6.50 and $15.00 per hour . . . 043

(3) More than $15.00 per hour 044

D3. Through collective bargaining, did your union offer any of these benefits?

Check all that apply.

050 ☐ Paid vacation
051 ☐ Paid sick leave
052 ☐ Life insurance
053 ☐ Disability insurance
054 ☐ Retirement/pension plans
055 ☐ Medical Savings Accounts (MSAs)
056 ☐ Flexible spending accounts

057 ☐ Cafeteria plan –

Enter the average annual value per member → 058 $ .00

D4. If your union has members at multiple locations, enter the total membership for all the locations.

034 ☐ Total membership for all locations

500 Remarks

Section E – PERSON COMPLETING THIS QUESTIONNAIRE

212 Name *(Please print)*	213 Title
Signature	214 Date

215 Telephone number ( )	220 Extension	216 FAX number ( )	217 E-Mail address

OMB No. 0935-0098: Approval Expires 04/30/98

FORM **MEPS-12(P)**
(7-8-97)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

PERSON-LEVEL QUESTIONNAIRE FOR UNIONS

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Sections 903(c) and 308(d) of that Act specify that all information will be held in strict confidence by the staff of the Agency for Health Care Policy and Research and their authorized contractors.

RETURN TO **Bureau of the Census**
1201 East 10th Street
Jeffersonville, IN 47132-0001

If you have any questions concerning this survey, please call 1–888–273–3878.

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

1. In this questionnaire, "this person" refers to the individual named in the label area. A permission slip signed by the individual authorizing our collection of this information is included at the back of this reporting package.
2. "Your organization" refers to the location on the label of this questionnaire.
3. For this survey, **a health insurance plan** is defined as providing **hospital and/or physician coverage** for a **single premium** to members and/or retirees. Also included in Section C of this questionnaire are single-service plans, which provide optional coverage not included in the basic health insurance plan(s) for an additional premium.

Section A – PERSON–LEVEL INFORMATION

A1. Which category below **best** describes this person's status with your union on July 1, 1996?

065
1 ☐ A full- or part-time member
2 ☐ A retired member
3 ☐ A former member
4 ☐ A relative/survivor of a former member

Go to Section D on page 3.

8 ☐ No record of this person – **Go to Section D on page 3.**

Section B – HOSPITAL OR PHYSICIAN PLAN

B1a. Was this person **eligible** for hospital/physician insurance coverage through your union on July 1, 1996?

350 1 ☐ Yes ↙ 2 ☐ No – **If No, go to Section C on page 3.**

If more than one plan was offered through this union, answer Part b below. If only one plan was offered, go to Question B2a.

b. Of the hospital/physician plans offered by your union, for which plans was this person eligible?

Please enter plan name(s) exactly as entered in Question B1 of the Union Questionnaire (MEPS-12) or Supplemental Sheet (MEPS-12(S)).

351 ☐ All **OR** ↙

501
502
503
504

B2a. Was this person **enrolled** in a hospital/physician plan provided by your union on July 1, 1996?

231 1 ☐ Yes ↙ 2 ☐ No – **If No, go to Section C on page 3.**

If more than one plan was offered through this union, answer Part b below. If only one plan was offered, go to Question B3.

b. In which hospital/physician plan(s) was this person enrolled?

Please enter plan name(s) exactly as entered in Question B1 of the Union Questionnaire (MEPS-12) or Supplemental Sheet (MEPS-12(S)).

352 ☐ All **OR** ↙

021
505

B3. What level of coverage did this person choose?

239
1 ☐ Single
2 ☐ Two adults
3 ☐ One adult/one child
4 ☐ Family (3 or more people)

B4. For the pay period including July 1, 1996, provide the information below regarding premiums paid for this person's hospital/physician coverage.

a. What was the **total premium including union and member contributions?**

If this plan was self-insured, *enter the monthly premium equivalent.*

361 $ .00 PER →

376
1 ☐ Week
2 ☐ 2 weeks
3 ☐ Month
4 ☐ Year

B4b. How much did **this person contribute** towards his/her coverage?

Report for the same premium period as in Question B4a.

362 $ .00

OR

353 ☐ Percent of insurance premium

c. How much did **your union contribute** towards this person's coverage?

Report for the same premium period as in Question B4a.

363 $ .00

OR

354 ☐ Percent of insurance premium

d. How much did sources other than your union, such as a government or employer, contribute towards/subsidize this person's coverage?

Report for the same premium period as in Question B4a.

355 $ .00

OR

356 ☐ Percent of insurance premium

OR

357 ☐ No subsidy/contribution from other sources – **Go to Section C on page 3.**

B5. What was the source of the outside subsidy or contribution reported in B4d?

Check only ONE.

358
2 ☐ Government
4 ☐ Employer
3 ☐ Other

Control No.

Section C – SINGLE-SERVICE PLANS

C1. On July 1, 1996, did this person obtain through your union any optional coverage (not included in his/her basic health plan reported in Section B above) at an additional premium?

246 1 ☐ Yes 2 ☐ No – **If No, go to Section D.**

C2. Which of the following single-service plans did this person obtain?

Check all that apply.

370 ☐ Dental
372 ☐ Vision
371 ☐ Prescription drugs
373 ☐ Long-term care

C3a. What was the total premium for all single-service plans obtained by this person, including union and member contributions?

374 $ .00 PER →

380 1 ☐ Week
2 ☐ 2 weeks
3 ☐ Month
4 ☐ Year

b. How much did **this person contribute** towards his/her single-service plan coverage?

Report for the same premium period as in Question C3a.

375 $ .00

OR

360 ☐ Percent of insurance premium

500 Remarks

Section D – PERSON COMPLETING THIS QUESTIONNAIRE

212 Name *(Please print)*	213 Title	
Signature		214 Date
215 Telephone number ( )	220 Extension	216 FAX number ( )	217 E-Mail address

OMB No. 0935-0098: Approval Expires 04/30/98

FORM **MEPS-12(S)**
(7-8-97)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

SUPPLEMENTAL SHEET
UNION QUESTIONNAIRE

INSTRUCTIONS

This Supplemental Sheet is a reprint of the questions in Section B of the Union Questionnaire (MEPS-12). You may use it to report additional health plan information. You may use photocopies of this Supplemental Sheet if sufficient copies were not included in your reporting package. Refer to the instructions on the first page of the Union Questionnaire (MEPS-12) when completing this Supplemental Sheet.

Section B – PLAN CHARACTERISTICS

B1. Enter the name of the health insurance plan and the insurance carrier.

FOR CENSUS USE ONLY

100

012 Name of plan

102 Name of insurance carrier

B2. Indicate the type of providers in this plan.

103
1 ☐ **Exclusive providers** – Enrollees must go to providers associated with the plan except in an emergency. There is typically no cost or a small fixed cost for each physician visit. (For example, HMOs, IPAs, EPOs)

2 ☐ **Any providers** – Enrollees can go to the physicians of their choice on a fee-for-service basis. The plan does not have any associated providers. (For example, conventional plans, indemnity plans)

3 ☐ **Mixture of preferred and any providers** – Enrollees can go to a set of "preferred" providers associated with the plan, or providers of their choice. If they go to a non-preferred provider, they face higher costs. (For example, PPOs, POSs)

B3. Did this plan **require** that the enrollee see a primary-care physician in order to be referred to a specialist?

104 1 ☐ Yes 2 ☐ No

B4. Indicate the type of indemnification of this plan.

105
1 ☐ **Purchased** from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses.

If purchased, go to Question B6.

2 ☐ **Self-insured** – Your union pays the claims from its resources and may charge a premium to members. The plan may be administered by a *third party*. This type may employ supplemental *stop-loss insurance* to limit unanticipated losses.

For self-insured plans only:

B5a. Indicate if you administered the plan or if you employed a third party.

106
1 ☐ Self-administered
2 ☐ Insurance company or other administrator

b. Did you purchase stop-loss coverage?

107 1 ☐ Yes 2 ☐ No

c. Enter this union's **total annual cost** of coverage for this plan for the plan year that included July 1, 1996. Include: claims paid, administrative costs, and stop-loss coverage (if any). Include union and member contributions.

108 $ .00

d. Enter the **monthly premium equivalents** for single and family (of four) coverage for a typical member. Include the costs entered in B5c. *Also enter this information in Question B9a (single) and B9b (family) – Total premium on page 2.*

109 $ .00 Single coverage

110 $ .00 Family coverage

B6. Did any enrollee receive a direct subsidy or contribution towards any part of the premium (e.g., from a government or employer)?

122 1 ☐ Yes 2 ☐ No

B7. In what month did the plan year begin?

Enter a numeric response (e.g., Jan = 01, May = 05). 123 ☐☐ Month

Section B – PLAN CHARACTERISTICS – Continued

B8a. For this plan, enter the total number of enrollees excluding dependents for this union on July 1, 1996.

124 ☐

b. Enter the total number of active members enrolled.

125 ☐

c. Enter the number of retirees enrolled.

127 ☐ Total 128 ☐ 65 and older

d. Enter the **total** number of enrollees with **single** coverage.

129 ☐

B9a. Enter this plan's **total** premium, union contribution, and member contribution for an enrollee with **single** coverage.

If self-insured, enter the monthly premium equivalent from Question B5d on page 1.

130 $ .00 Total premium

131 $ .00 Union contribution

132 $ .00 Member contribution

Indicate the premium period

133 1 ☐ Week 2 ☐ 2 weeks 3 ☐ Month 4 ☐ Year

b. Enter this plan's **total** premium, union contribution, and member contribution for an enrolled **family** (of four).

Report for the same premium period as Question B9a.

If self-insured, enter the monthly premium equivalent from Question B5d on page 1.

134 $ .00 Total premium

135 $ .00 Union contribution

136 $ .00 Member contribution

137 ☐ Family coverage was not offered

B10a. Did the **premiums** (not contributions) vary by –

Check all that apply.

138 ☐ Age?
139 ☐ Sex?
140 ☐ Number of persons (within family coverage)?
142 ☐ Other? – *Specify*
099 ☐

B10b. Did the **amount of the member contribution** (not premium) vary for different member categories (e.g., full-time, part-time, senority, work site, occupation)?

143 1 ☐ Yes 2 ☐ No

B11. Did this plan's **premium** include either of these services?

Check all that apply.

144 ☐ Life insurance 145 ☐ Disability insurance

B12. Enter the **annual deductibles** that enrollees paid out of their pockets before the plan began paying for covered services (using the plan's providers). Many HMO-type plans do not have deductibles.

146 $ .00 **Total individual annual deductible OR**

Separate deductibles for:

147 $ .00 Physician care

148 $ .00 Hospital care

If the deductible is per overnight hospital stay, report under B13a.

149 $ .00 **Total family annual deductible** *(if applicable)*

150 ☐ Number of persons – *Enter if the plan also specified that the family deductible was met when a number of family members fulfilled their individual deductibles.*

151 ☐ Plan did not have a deductible

B13a. How much did an **enrollee** pay for an **overnight hospital stay** (in a participating hospital, if applicable) after any annual deductible was met?

152 $ .00 → 154 1 ☐ Per day 2 ☐ Per stay

OR

153 ☐ Percent

OR

155 ☐ Hospital care was not covered

b. How much did an **enrollee** pay for an **office visit** (with a participating physician, if applicable) after any annual deductible was met?

156 $ .00

OR

157 ☐ Percent

OR

218 ☐ Physician care was not covered

Control No.

Section B – PLAN CHARACTERISTICS – Continued

B14. What was the maximum amount this plan would have paid for an individual –

a. Over the enrollee's lifetime?

159 $ .00

b. In one year?

160 $ .00

158 ☐ No maximum

B15. What was the maximum annual out-of-pocket amount for –

a. An individual?

161 $ .00

b. A family (of four)?

162 $ .00

163 ☐ No maximum

B16. Indicate which of these services were included in the plan.

Check all that apply.

164 ☐ Routine mammograms
165 ☐ Adult routine physical exams
166 ☐ Routine pap smears

167 ☐ Office visits for prenatal care

168 ☐ Adult immunizations
169 ☐ Child immunizations

170 ☐ Well-baby care, under 1 year
171 ☐ Well-child care, 1–4 years
172 ☐ 100% well-baby care

173 ☐ Chiropractic care
174 ☐ Other non-physician providers
175 ☐ Outpatient prescriptions

176 ☐ Routine dental care
177 ☐ Orthodontic care

178 ☐ Nursing home care
179 ☐ Home health care

180 ☐ Inpatient mental illness
181 ☐ Outpatient mental illness
182 ☐ Alcohol/substance abuse treatment

B17. Could this plan have refused to cover persons with certain preexisting conditions?

183 1 ☐ Yes 2 ☐ No

Did this happen in 1996?

184 1 ☐ Yes 2 ☐ No

B18. Could this plan have imposed a waiting period for persons with certain preexisting conditions?

185 1 ☐ Yes 2 ☐ No

B19a. Is this plan offered in 1997?

186 1 ☐ Yes – **If Yes, go to Question B19c.**
2 ☐ No

b. If it is not still offered, indicate if it has been –

187 1 ☐ Replaced with a similar plan
2 ☐ Replaced by a substantially different plan
3 ☐ Dropped without offering a replacement – **END THIS FORM.**

c. For 1997, enter the single and family enrollments and premiums for this plan or the one that took its place.

Report for the same premium period as in Question B9a on page 2.

188 ☐ Single enrollment

189 ☐ Family enrollment

190 $ .00 Single premium

191 $ .00 Family premium

500 Remarks

OMB No. 0935-0098: Approval Expires 04/30/98

FORM **MEPS-13**
(7-8-97)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

SELF-EMPLOYED QUESTIONNAIRE

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Your report to the Census Bureau is **confidential** by law (Title 13, United States Code). It may be seen only by sworn Census employees and may be used only for statistical purposes.

RETURN TO **Bureau of the Census**
1201 East 10th Street
Jeffersonville, IN 47132-0001

If you have any questions concerning this survey, please call 1–888–273–3878.

Please correct errors in name, address, and ZIP Code. ENTER number and street if not shown.

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

1. For this survey, **a health insurance plan** is defined as providing **hospital and/or physician coverage** for a **single premium** to the enrollee. Exclude extra-cash plans (a specified number of dollars per day in the hospital) or dread-disease (e.g., cancer-only) plans.
2. Section C requests information on plans providing coverage for a single service, such as dental, drug, or vision coverage, at an additional cost.
3. **Estimates** are acceptable if you do not have this information readily available.
4. Provide information for the **period that included July 1, 1996**. However, **annual** costs should be reported for **calendar year 1996**, if possible, or for the plan year that included July 1, 1996.

Section A – HEALTH INSURANCE INFORMATION

A1. On July 1, 1996, did you operate a business or profession that produced self-employment income, with no paid employees other than yourself?

225 1 ☐ Yes 2 ☐ No – **If No, go to Section E on page 4.**

A2a. Were you covered by a public health insurance plan on July 1, 1996?

226 1 ☐ Yes 2 ☐ No – **If No, go to Question A3a.**

b. Indicate the type(s) of public health insurance by which you were covered on July 1, 1996.

Check all that apply.

227 ☐ Medicaid
228 ☐ Medicare
229 ☐ CHAMPUS/CHAMPVA
230 ☐ Other public health insurance

A3a. Were you covered by a private health insurance plan(s) that covered hospital and/or physician services on July 1, 1996?

231 1 ☐ Yes 2 ☐ No – **If No, go to Section C on page 3.**

b. Which of these categories **best** describes how you obtained (each of) your health insurance plans?

Check all that apply.

232 ☐ From your current or former spouse's employer plan
233 ☐ From your current or previous employer

Complete Section C on page 3.

234 ☐ From an insurance carrier or HMO
235 ☐ From a union
236 ☐ From a trade/ professional association
237 ☐ From a pooling arrangement (e.g., a small business group)
238 ☐ Other – *Specify*
098 [ ]

Complete Section B on page 2.

Section B – PLAN CHARACTERISTICS

Provide information for the hospital and/or physician plan(s) in which you were enrolled on **July 1, 1996**. Exclude any plan(s) in which you may have been covered through your or your spouse's current or former employer. If you have more than one hospital and/or physician plan, please make a copy of Section B and complete it for each plan.

B1. What was the name of the health insurance plan and its carrier, covering hospital and/or physician services, in which you were enrolled on July 1, 1996?

FOR CENSUS USE ONLY

100

012 Name of plan

102 Name of insurance carrier

B2. Indicate the type of providers in this plan.

103

1 ☐ **Exclusive providers** – Enrollees must go to providers associated with the plan except in an emergency. There is typically no cost or a small fixed cost for each physician visit. (For example, HMOs, IPAs, EPOs)

2 ☐ **Any providers** – Enrollees can go to the physicians of their choice on a fee-for-service basis. The plan does not have any associated providers. (For example, conventional plans, indemnity plans)

3 ☐ **Mixture of preferred and any providers** – Enrollees can go to a set of "preferred" providers associated with the plan, or providers of their choice. If they go to a non-preferred provider, they face higher costs. (For example, PPOs, POSs)

B3. Did this plan **require** that you see a primary-care physician in order to be referred to a specialist?

104 1 ☐ Yes 2 ☐ No

B4. Indicate the level of coverage purchased:

239

1 ☐ Single
2 ☐ Two adults
3 ☐ One adult/one child
4 ☐ Family (3 or more people)

B5. What was the total premium paid for this hospital and/or physician plan?

361 $ .00 → 376

3 ☐ Monthly
4 ☐ Yearly
5 ☐ Quarterly
6 ☐ Semi-annually

B6. Did you receive a direct subsidy or contribution towards this plan's premium from another source, such as a government?

122 1 ☐ Yes 2 ☐ No

B7. Enter the **annual deductibles** required out of your pocket before the plan began paying for covered services (using the plan's providers). Many HMO-type plans do not have deductibles.

146 $ .00 **Total individual annual deductible** **OR**

Separate deductibles for:

147 $ .00 Physician care

148 $ .00 Hospital care

If the deductible is per overnight hospital stay, report under B8a.

149 $ .00 **Total family annual deductible** *(If applicable)*

150 ☐ Number of persons – *Enter if the plan also specified that the family deductible was met when a number of family members fulfilled their individual deductibles.*

151 ☐ Plan did not have a deductible

B8a. How much would you have paid for an **overnight hospital stay** (in a participating hospital, if applicable) after any annual deductible was met?

152 $ .00 → 154 1 ☐ Per day 2 ☐ Per stay

OR

153 ☐ Percent

OR

155 ☐ Hospital care was not covered

b. How much would you have paid for an **office visit** (with a participating physician, if applicable) after any annual deductible was met?

156 $ .00

OR

157 ☐ Percent

OR

218 ☐ Physician care was not covered

B9. What was the maximum amount this plan would have paid –

a. Over your lifetime?

159 $ .00

b. In one year?

160 $ .00

158 ☐ No maximum

Control No.

Section B – HEALTH INSURANCE PLAN INFORMATION – Continued

B10. What was the maximum annual out-of-pocket amount you could have paid?

241 $ .00

163 ☐ No maximum

B11. Indicate which of these services were included in the plan.

Check all that apply.

164 ☐ Routine mammograms
165 ☐ Adult routine physical exams
166 ☐ Routine pap smears

167 ☐ Office visits for prenatal care

168 ☐ Adult immunizations
169 ☐ Child immunizations

170 ☐ Well-baby care, under 1 year
171 ☐ Well-child care, 1–4 years
172 ☐ 100% well-baby care

173 ☐ Chiropractic care
174 ☐ Other non-physician providers
175 ☐ Outpatient prescriptions

176 ☐ Routine dental care
177 ☐ Orthodontic care

178 ☐ Nursing home care
179 ☐ Home health care

180 ☐ Inpatient mental illness
181 ☐ Outpatient mental illness
182 ☐ Alcohol/substance abuse treatment

B12. Could this plan have imposed a waiting period for persons with certain preexisting conditions?

185 1 ☐ Yes 2 ☐ No 3 ☐ Don't know

B13a. Are you currently enrolled in the same health plan this year?

242 1 ☐ Yes – **If Yes, go to Question B13c.**
2 ☐ No

b. What type of health plan replaced the one you had in 1996?

243 1 ☐ Similar plan
2 ☐ Substantially different plan
3 ☐ No longer purchase a health plan – **Go to Section C.**

c. What is your 1997 premium for this plan or the one that took its place?

244 $ .00 → 245
3 ☐ Monthly
4 ☐ Yearly
5 ☐ Quarterly
6 ☐ Semi-annually

Section C – SINGLE-SERVICE PLAN INFORMATION

C1. Did you obtain any **optional** single-service coverage (not included in your basic hospital and/or physician coverage) at an additional premium?

246 1 ☐ Yes 2 ☐ No – **If No, go to Section D on page 4.**

C2. Which of the following single-service plans did you purchase?

Check all that apply.

370 ☐ Dental
372 ☐ Vision
371 ☐ Prescription drugs
373 ☐ Long-term care

C3. What was the total premium paid for your single-service plan(s)?

374 $ .00 → 380
3 ☐ Monthly
4 ☐ Yearly
5 ☐ Quarterly
6 ☐ Semi-annually

Section D – SELF-EMPLOYMENT INFORMATION

D1. How long have you operated this business/profession?

064 ☐ Years

D2. Which of these categories **best** describes your principal business activity (i.e., generates MOST of your revenue)?

Check only ONE.

060
1 ☐ Retail (sell to general public)
2 ☐ Personal services (e.g., beauty shops, dry cleaners)
3 ☐ Business services (e.g., advertising, computer processing)
4 ☐ Other services (e.g., legal and health services)
5 ☐ Manufacturing
6 ☐ Wholesale trade (sell to businesses and industry)
7 ☐ Finance, insurance, or real estate
8 ☐ Transportation, communications, electric, gas, or sanitary services
9 ☐ Construction
10 ☐ Agriculture or forestry

Section E – DEMOGRAPHIC INFORMATION

Unless otherwise directed, please answer the following demographic questions as they pertained to you on July 1, 1996. The following characteristics of business owners are being used for statistical purposes only.

E1. What is your sex?

248 1 ☐ Male 2 ☐ Female

E2. What was your age on July 1, 1996?

249
1 ☐ Under 24
2 ☐ 24–34
3 ☐ 35–44
4 ☐ 45–54
5 ☐ 55–64
6 ☐ 65 or over

E3. What is the highest level of education you have obtained?

250
1 ☐ Some high school
2 ☐ High school degree or G.E.D.
3 ☐ Some college
4 ☐ Undergraduate/Bachelor's degree (B.S., B.A., etc.)
5 ☐ Graduate studies

E4. What is your marital status?

251
1 ☐ Single, never married
2 ☐ Married, spouse employed
3 ☐ Married, spouse not employed
4 ☐ Separated
5 ☐ Divorced
6 ☐ Widowed

E5. Including yourself and your spouse, how many dependents do you have?

257 ☐ Number of dependents

E6a. Are you of Hispanic, Latino, or Spanish origin?

258 1 ☐ Yes 2 ☐ No

b. Which group best represents your race?

Check only ONE.

259
1 ☐ American Indian
2 ☐ Aleut, Eskimo
3 ☐ Asian or Pacific Islander
4 ☐ Black
5 ☐ White
6 ☐ Other

E7. What was your 1996 annual household income? **(Household income for all family members after business expenses.)**

260
1 ☐ Under $25,000
2 ☐ $25,000 – $44,999
3 ☐ $45,000 – $74,999
4 ☐ $75,000 – $99,999
5 ☐ $100,000 and over

500 Remarks

Section F – PERSON COMPLETING THIS QUESTIONNAIRE

212 Name *(Please print)*	213 Title
Signature	214 Date
215 Telephone number ( )	220 Extension / 216 FAX number ( ) / 217 E-Mail address

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

OMB No. 0935-0098: Approval Expires 04/30/98

FORM **MEPS-14(P)**
(7-7-97)

U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

MEDICAL EXPENDITURE PANEL SURVEY (INSURANCE COMPONENT)

INSURANCE PROVIDER QUESTIONNAIRE

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Sections 903(c) and 308(d) of that Act specify that all information will be held in strict confidence by the staff of the Agency for Health Care Policy and Research and their authorized contractors.

RETURN TO **Bureau of the Census**
1201 East 10th Street
Jeffersonville, IN 47132-0001

If you have any questions concerning this survey, please call 1–888–273–3878.

Please correct errors in name, address, and ZIP Code. ENTER street and number if not shown.

A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS

1. For this survey, **a health insurance plan** is defined as providing **hospital and/or physician coverage** for a **single premium** to the enrollee.
2. Section C requests information on plans providing coverage for a single service, such as dental, drug, or vision coverage, at an additional cost.
3. **Estimates** are acceptable if you do not have this information readily available.
4. Provide information for the **period that included July 1, 1996**. However, **annual** costs should be reported for **calendar year 1996**, if possible, or for the plan year that included July 1, 1996.

Section A – HEALTH INSURANCE INFORMATION

A1. Did this company provide health insurance coverage on July 1, 1996, to the person named in the label area of this questionnaire?

310
1 ☐ Yes
2 ☐ No – **If No, go to Section D on page 3.**

A2a. Did your company provide a hospital and/or physician plan (including Medigap) to this person?

311
1 ☐ Yes – **If Yes, go to Section B on page 2.**
2 ☐ No

A2b. Did your company provide a single-service plan to this person?

312
1 ☐ Yes – **If Yes, go to Section C on page 3.**
2 ☐ No

c. Did your company provide a dread-disease or extra-cash plan to this person?

313
1 ☐ Yes – **If Yes, go to Section D on page 3.**
2 ☐ No – **If No, go to Section B on page 2.**

Section B – PLAN CHARACTERISTICS

Please provide information for the plan in which the person named in the label was enrolled on July 1, 1996.

Answer the questions only for the hospital/physician insurance plan which covered a set of benefits (including hospital stays and /or physician visits) for a single premium. Additional benefits such as dental, vision, or prescription drugs may be included in these plans.

B1. What was the name of the plan in which this person was enrolled on July 1, 1996?

012 Name of plan

B2a. Was this a Medigap plan?

275 1 ☐ Yes 2 ☐ No – **If No, go to Question B3.**

b. Which of the 10 common plans, identified by letters "A–J", is this Medigap plan?

276 ☐

OR

277 ☐ Not applicable

c. Is the premium for this Medigap plan issue-age rated or attained-age rated?

278
1 ☐ Issue-age rated
2 ☐ Attained-age rated
3 ☐ Neither

B3. Was this person's enrollment financed through Medicare or Medicaid?

279
1 ☐ Medicare
2 ☐ Medicaid
3 ☐ Neither

B4a. For the period including July 1, 1996, was this person's plan a group policy?

280 1 ☐ Yes ↙ 2 ☐ No

b. How many policyholders were in the group?

281 ☐

B5. What type of plan did your company provide to this person?

Check only ONE.

282
1 ☐ Conventional Health Insurance (Fee-for-Service)
2 ☐ PPO (Preferred Provider Organization)
3 ☐ HMO (Health Maintenance Organization)
4 ☐ EPO (Exclusive Provider Organization)
5 ☐ POS/Open Ended HMO (Point of Service)
6 ☐ Other – *Specify*

097 ☐

B6. What was this plan's premium for this person?

361 $ .00 → 376
3 ☐ Monthly
4 ☐ Yearly
5 ☐ Quarterly
6 ☐ Semi-annually

B7. What level of coverage did this person hold?

239
1 ☐ Single
2 ☐ Two adults
3 ☐ One adult, one child
4 ☐ Family (3 or more people)

B8. Was there a waiting period for this person before his/her plan benefits began?

290 1 ☐ Yes 2 ☐ No

B9a. Was a summary of this person's recent health history required for enrollment in this plan?

291 1 ☐ Yes 2 ☐ No

b. Was a physical examination required for enrollment in this plan?

292 1 ☐ Yes 2 ☐ No

B10a. Is this plan community rated?

293 1 ☐ Yes ↙ 2 ☐ No – **If No, go to Question B11 on page 3.**

b. How is this plan rated?

Check all that apply.

294 ☐ Age
295 ☐ Geographic area
296 ☐ Other

} **Go to Question B12a on page 3.**

Control No.

Section B – PLAN CHARACTERISTICS– Continued

B11. For this plan, which of the following characteristics affected the premium amount?

Check all that apply.

297 ☐ Age
298 ☐ Health enhancing habits
299 ☐ Smoking
300 ☐ Other health endangering habits/hobbies
301 ☐ Geographic area
302 ☐ Specific medical conditions
303 ☐ Other

B12a. Did any characteristics preclude enrollment in this plan?

304 1 ☐ Yes → 2 ☐ No – **If No, go to Section C.**

b. Which of the following characteristics precluded enrollment in this plan?

Check all that apply.

305 ☐ Age
306 ☐ Smoking
307 ☐ Other health endangering habits/hobbies
308 ☐ Specific medical conditions
309 ☐ Other

Section C – SINGLE-SERVICE PLANS

C1. Did your company provide single-service plan coverage to this person at an additional premium?

246 1 ☐ Yes 2 ☐ No – **If No, go to Section D.**

C2. Which of the following single-service plans did your company provide to this person?

Check all that apply.

370 ☐ Dental
371 ☐ Prescription drugs
372 ☐ Vision
373 ☐ Long–term care

C3. What was the total premium this person paid for his/her single-service plan(s)?

374 $ .00 → 380
3 ☐ Monthly
4 ☐ Yearly
5 ☐ Quarterly
6 ☐ Semi-annually

C4. What level of coverage did this person hold?

314 1 ☐ Single
2 ☐ Two adults
3 ☐ One adult, one child
4 ☐ Family (3 or more people)

500 Remarks

Section D – PERSON COMPLETING THIS QUESTIONNAIRE

212 Name *(Please print)*	213 Title
Signature	214 Date
215 Telephone number ( )	220 Extension
216 FAX number ( )	217 E-Mail address